

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)  
15M 9/59

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2018  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
01994

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>11 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Florida</b> b. COUNTY <b>Jacksonville</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Jacksonville</b> d. STREET ADDRESS <b>2304 Forest Hills Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>Mitchell</b> Last <b>Acres</b>		4. DATE OF DEATH Month <b>February</b> Day <b>17</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 25, 1938</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Attendant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Filling Station</b>	11. BIRTHPLACE (State or foreign country) <b>Tennessee</b>
13. FATHER'S NAME <b>Charles O. Acres</b>		14. MOTHER'S MAIDEN NAME <b>Velma Crabtree</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>1956-57 413-58-2192</b>	
17. INFORMANT <b>The Medical Record</b>		Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arrhythmia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Viral Myocarditis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>Unknown</b> <b>4 years</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>February 6, 1961</b> to <b>February 17, 1961</b> , that (I) (we) last saw the deceased alive on <b>Feb. 17, 1961</b> , and that death occurred at <b>6:45 a.m.</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Thomas E. Gaffney</b>		22b. DATE SIGNED <b>2/17-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>THOMAS E. GAFFNEY, M.D.</b>		22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-transit 2-18-61</b>		23b. DATE THEREOF <b>2-18-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Restlawn Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Jacksonville, Florida</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>ROBERT A. PUMPHREY</b>		25a. REC'D BY REGISTRAR <b>FEB 21 '61</b>	
ADDRESS <b>Bethesda, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

5018

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Final Inspection

Approved

4/13/57

UNITED STATES DEPARTMENT OF AGRICULTURE

ROBERT A. HENNING

2019

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

01995

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Connecticut</b> b. COUNTY <b>✓</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>5 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Monroe</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				d. STREET ADDRESS <b>R.F.D. #4</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Crawford</b> Last <b>Allen</b>				4. DATE OF DEATH Month <b>February</b> Day <b>20,</b> Year <b>19 61</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>January 18, 1926</b>	
9. AGE (In years lost birthday) <b>35</b> yrs.		IF UNDER 1 YEAR Months <b>35</b> Days <b>35</b> Hours <b>35</b> Min.		IF UNDER 24 HRS. Months <b>35</b> Days <b>35</b> Hours <b>35</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life) <b>Airlines Station Manager</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Airlines</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>John C. Allen Sr.</b>				14. MOTHER'S MAIDEN NAME <b>Sarah P. Wald</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>				16. SOCIAL SECURITY NO. <b>047-12-6314</b>		17. INFORMANT <b>The Medical Records</b> <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CNS Metastases</b> DUE TO <b>1953</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <b>Carcinoma, I not known ? Adrenal Glands</b> DUE TO (c) <b>10 days</b>						INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>February 15, 19 61</b> to <b>February 20, 19 61</b> , that (I) (we) last saw the deceased alive on <b>February 20 61</b> and that death occurred at <b>9:20 p.m.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Michael Z. Lazor</b>				22b. DATE <b>2/21/61</b>		22c. PHYSICIAN'S NAME (Type) <b>MICHAEL Z. LAZOR, M.D.</b>	
22d. ADDRESS <b>The Clinical Center National Institutes Of Health Bethesda 14, Maryland</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/22/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Fresh Pond</b>		23d. LOCATION (City, town, or county) (State) <b>Middle Village N.Y.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. W. Chambers Co. 1400 Chapin St NW</b>				25a. REC'D BY REGISTRAR <b>FEB 23 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Curtis L. Francis</b>	

STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

1. Name of deceased: John Doe  
2. Sex: Male  
3. Age: 45  
4. Date of birth: Jan 1, 1900  
5. Place of birth: New York City  
6. Race: White  
7. Occupation: Teacher  
8. Cause of death: Heart Disease  
9. Date of death: Dec 15, 1945  
10. Place of death: Home  
11. Signature of physician: [Signature]  
12. Signature of registrar: [Signature]

13. Name of informant: John Doe  
14. Address of informant: 123 Main St, New York City  
15. Date of report: Dec 16, 1945  
16. Signature of informant: [Signature]  
17. Signature of registrar: [Signature]  
18. Signature of physician: [Signature]  
19. Signature of medical examiner: [Signature]  
20. Signature of coroner: [Signature]



## CERTIFICATE OF DEATH

Reg. Dist. No. 01996

2020

1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>DISTRICT OF COLUMBIA</u> b. COUNTY <u>WASHINGTON</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LAKOMA PARK</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASHINGTON SANITARIUM &amp; HOSPITAL</u>		d. STREET ADDRESS <u>1206 JUNIPER ST. N.W.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>LETCHER CALEB ANDERSON</u>		4. DATE OF DEATH Month Day Year <u>FEBRUARY 20<sup>th</sup> 1961</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG. 29, 1884</u>
9. AGE (In years last birthday) <u>74</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED - CAPT. TRANSIT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>VIRGINIA</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James ANDERSON</u>		14. MOTHER'S MAIDEN NAME <u>HARRIET</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>578-10-5408</u>	
17. INFORMANT <u>HOSP. RECORDS - 7600 CARROLL AVE.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL PERFORATION</u> 420. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>MYOCARDIAL INFARCTION</u> DUE TO (c) <u>ATHERO SCLEROSIS</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 Hour</u> <u>5 days -</u> <u>UNKNOWN</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>FEB 15, 1961</u> to <u>FEB 20, 1961</u> , that I last saw the deceased alive on <u>FEB 19, 1961</u> , and that death occurred at <u>5:20 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Jos. Berkenbilt</u> M.D.		ADDRESS (Street, city or town, state) <u>1025 VERMONT AVE NW</u>	
PHYSICIAN'S NAME (Type) <u>JOS. BERKENBILT</u>		DATE SIGNED <u>WASH. 5 D.C.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2-23-61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Georgetown Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Switzerland Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hanson Funeral Home</u> ADDRESS <u>- 3851 GA Ave.</u>		24a. REC'D BY REGISTRAR <u>FEB 24 '61</u>	
		24b. REGISTRAR'S SIGNATURE <u>C. E. H.</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in. The funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

0501

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with  
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)  
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

2021

01997

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>HOWARD</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b>				c. LENGTH OF STAY IN 1b <b>3 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HIGHLAND</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MONTGOMERY GENERAL HOSPITAL</b>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>MARY LYDIA ANDERSON</b>				4. DATE OF DEATH Month Day Year <b>FEBRUARY 13 19 61</b>					
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov 25, 1889</b>			
9. AGE (In years lost birthday) <b>71</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Same</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>			
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>									
13. FATHER'S NAME <b>JOHN SCHAFER</b>				14. MOTHER'S MAIDEN NAME <b>SARAH FRANCES RIDLEY</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>—</b>		17. INFORMANT Address <b>HOSPITAL RECORDS, OLNEY, MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL HEMORRHAGE, RIGHT HEMISPHERE</b> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <b>ARTERIAL HYPERTENSION</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>NEPHROSCLEROSIS</b>								INTERVAL BETWEEN ONSET AND DEATH <b>4 DAYS</b> <b>15 YEARS</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>1948</b> to <b>FEB. 13, 1961</b> , that (I) (we) last saw the deceased alive on <b>FEB. 12, 1961</b> , and that death occurred at <b>6:20</b> A.M. from the causes and on the date stated above.									
22a. SIGNATURE <b>Charles S. Whitaker, B. P.</b>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>2/13/61</b>			
22c. PHYSICIAN'S NAME (Type) <b>CHARLES S. WHITAKER, M. D.</b>				22d. ADDRESS <b>CLARKSVILLE, MD.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/15/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parkside Chapel</b>		23d. LOCATION (City, town, or county) (State) <b>Bowie Md</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Elle Witt Donaldson, Laurel, Md</b>				25a. REC'D BY REGISTRAR <b>FEB 20 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hanna</b>			

8021

STATE OF DEATH

NORTHERN GENERAL HOSPITAL

DEATH

NORTHERN GENERAL HOSPITAL

DEATH

U. S. A.

JOHN SCHAFER

JOHN SCHAFER

GENERAL HOSPITAL, 1000 WEST 10TH

ARTERIAL HYPERTENSION

HEMOGLOBIN

FEB. 13 1941

FEB. 12 1941

201581

CLARKVILLE, MO.

CHARLES J. PHILLIPS, M.D.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

2022

01998

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>7 yrs. 2 mo</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Wash. Jan'y Hosp.</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution; Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> d. STREET ADDRESS <u>3701 MASS AVE. Apt 509</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
<b>3. NAME OF DECEASED</b> (Type or print) <u>Evelyn</u> First <u>Fant</u> Middle <u>Avery</u> Last			<b>4. DATE OF DEATH</b> <u>Feb</u> Month <u>21</u> Day <u>1961</u> Year											
<b>5. SEX</b> <u>F</u>		<b>6. COLOR OR RACE</b> <u>W</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>										
<b>8. DATE OF BIRTH</b> <u>7-21-84</u>		<b>9. AGE</b> (In years last birthday) <u>74</u> yrs.		<b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>										
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Wife</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>  </u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Ogden, Utah</u>										
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>American</u>		<b>13. FATHER'S NAME</b> <u>Joseph N. Fant</u>												
<b>14. MOTHER'S MAIDEN NAME</b> <u>MARIANA B. Mears</u>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No.</u>												
<b>16. SOCIAL SECURITY NO.</b> <u>NONE</u>		<b>17. INFORMANT</b> <u>Jessie F. Evans (Sister)</u> <u>3705 Lowell St. N.W. Wash, DC</u>												
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) <table style="width: 100%;"> <tr> <td style="width: 30%;"> <b>PART I. DEATH WAS CAUSED BY:</b>  <b>IMMEDIATE CAUSE (a)</b>  <u>Cerebral Hemorrhage with</u> </td> <td style="width: 10%;"> <b>DUE TO</b> </td> <td style="width: 60%;"> <b>INTERVAL BETWEEN ONSET AND DEATH</b>  <u>Eight years</u> </td> </tr> <tr> <td> <b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b>  <b>(b)</b>  <u>Recurrance</u> </td> <td> <b>DUE TO</b> </td> <td> <u>3 months</u> </td> </tr> <tr> <td> <b>(c)</b>  <u>Arteriosclerosis</u> </td> <td></td> <td> <u>3 years</u> </td> </tr> </table>						<b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <u>Cerebral Hemorrhage with</u>	<b>DUE TO</b>	<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>Eight years</u>	<b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b> <b>(b)</b> <u>Recurrance</u>	<b>DUE TO</b>	<u>3 months</u>	<b>(c)</b> <u>Arteriosclerosis</u>		<u>3 years</u>
<b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <u>Cerebral Hemorrhage with</u>	<b>DUE TO</b>	<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>Eight years</u>												
<b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b> <b>(b)</b> <u>Recurrance</u>	<b>DUE TO</b>	<u>3 months</u>												
<b>(c)</b> <u>Arteriosclerosis</u>		<u>3 years</u>												
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>														
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, notify medical examiner) <input type="checkbox"/>														
<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)														
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>19</u> p.m. <u>  </u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)										
<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>										
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>June 2-20-1961</u> <b>to</b> <u>Feb. 21, 1961</u> <b>that (I) (we) last saw the deceased alive on</b> <u>2-20-1961</u> <b>and that death occurred at</b> <u>2:20 P.M.</u> <b>from the causes and on the date stated above.</b>														
<b>22a. SIGNATURE</b> <u>Robert A. Hare</u>				<b>22b. DATE SIGNED</b> <u>Feb 23 '61</u>										
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>Robert A. Hare</u>				<b>22d. ADDRESS</b> <u>7600 Carroll Ave. Tak. Park, Md</u>										
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>BURIAL</u>		<b>23b. DATE THEREOF</b> <u>2-25-1961</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>CONGRESSIONAL CEMETERY</u>										
<b>23d. LOCATION (City, town or county)</b> <u>WASHINGTON, DC</u>		<b>(State)</b>												
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Joseph Gauder's Sons, Inc. 1756 Park Ave N.W.</u>				<b>25a. REC'D BY REGISTRAR</b> <u>Feb 23 '61</u>										
<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles S. Hare</u>				<b>DATE</b>										

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed after the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
 15M 9/60

5052



*[Faint, mostly illegible text covering the page, possibly bleed-through from the reverse side.]*



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 2023 Item 2 FilmG281 2-17-61 et CERTIFICATE OF DEATH

Reg. Dist. No. **01999**

<b>1. PLACE OF DEATH</b> a. COUNTY <b>MONTGOMERY</b> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Germantown</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Marylander Rest Home</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Florida</b> <span style="float: right;">b. COUNTY <b>MONTGOMERY</b> ?</span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Germantown St. Petersburg</b> d. STREET ADDRESS <b>811 Jackson St., Apt. A</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
<b>3. NAME OF DECEASED</b> (Type or print) <b>ELIZABETH H. BABCOCK</b> First Middle Last				<b>4. DATE OF DEATH</b> <b>Feb. 10, 1961</b> Month Day Year													
<b>5. SEX</b> <b>Female</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>July 9, 1883</b>		<b>9. AGE</b> (In years last birthday) <b>77</b> yrs.		<b>IF UNDER 1 YEAR</b> Months Days Hours Min.		<b>IF UNDER 24 HRS.</b> Hours Min.					
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Nurse</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>New Jersey</b>				<b>11. BIRTHPLACE</b> (State or foreign country) <b>New Jersey</b>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>US</b>					
<b>13. FATHER'S NAME</b> <b>Wright Babcock</b>						<b>14. MOTHER'S MAIDEN NAME</b> <b>Adelaide Grinnell</b>											
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b> <b>None</b>				<b>INFORMANT</b> <b>4831 N. Old Dominion Dr. Arlington, Va.</b> <b>Dudley P. Babcock-</b>									
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Edema</b> <b>526X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <b>Congestive Heart Failure</b> DUE TO (c) <b>Bronchiectasis + Cor Pulmonale</b>												<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>12 hrs</b> <b>4 weeks</b> <b>Indefinite</b>					
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <b>Severe Rheumatoid Arthritis</b>														<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)													
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <b>19</b>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)									
<b>21. I certify that I attended the deceased from</b> <b>12/2/1960</b> , to <b>2/10/1961</b> , that I last saw the deceased alive on <b>2/10/1961</b> , and that death occurred at <b>12:30 P.M.</b> from the causes and on the date stated above. <b>ADDRESS</b> (Street, city or town, state) <b>DATE SIGNED</b> <b>2/10/61</b>																	
<b>ACTUAL SIGNATURE</b> <b>Stephen N. Jones</b> <b>M.D.</b>				<b>PHYSICIAN'S NAME (Type)</b> <b>Stephen N. Jones-Rockville, Maryland</b>													
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Bur-Transit</b>				<b>22b. DATE THEREOF</b> <b>2/14/61</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Trinity</b>				<b>22d. LOCATION (City, town, or county)</b> <b>New York City, New York</b> (State)							
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Tyson Wheeler</b> <b>ADDRESS</b> <b>1331 E. Montgomery Ave. Rockville, Md.</b>														<b>24a. REC'D BY REGISTRAR</b> <b>FEB 14 '61</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be returned to the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1900

CERTIFICATE OF DEATH

1903

Blank certificate form with horizontal lines for text entry.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
ISM 9/59

2024  
MONTGOMERY  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

02000

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>3 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Kathleen</b> Last <b>Balzer</b>		4. DATE OF DEATH Month <b>Feb.</b> Day <b>4,</b> Year <b>19 61</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>FEB. 1, 1961</b>
9. AGE (In years lost birthday) yrs. <b>3</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>3</b> Days <b>5</b> Hours <b>5</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Thomas J. Balzer</b>		14. MOTHER'S MAIDEN NAME <b>Frances Jeanne Miller</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Thomas J. Balzer</b>		18. ADDRESS <b>102 Cedar Ave. Gaithersburg, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cardiovascular collapse</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost. (b) <b>multiple congenital anomalies</b> DUE TO (c) <b>birth anomalies</b> INTERVAL BETWEEN ONSET AND DEATH <b>3 days 5 hrs</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <b>omphalocoel</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>2/1</b> 19 <b>61</b> , to <b>2/4</b> 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>2/3</b> 19 <b>61</b> , and that death occurred at <b>9:45</b> A.M. from the causes and on the date stated above.			
22a. SIGNATURE <b>Wilfred R. Ehrmentraut</b>		22b. DATE <b>2/4/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Wilfred R. Ehrmentraut MD</b>		22d. ADDRESS <b>4890 Battery Lane Bethesda Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/11/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>St. Rosa Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Cloppers, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		25a. REC'D BY REGISTRAR <b>FEB 14 '61</b>	
ADDRESS <b>Bethesda, Maryland</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

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# CENTRAL OF DEATH

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Items 11, 12 Film G281 2-20-61

02001

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>D.C.</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TARDOMA PARK</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WASHINGTON</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>577 ALBANY AVE.</b>		d. STREET ADDRESS <b>4508 CHESAPEAKE</b>	
3. NAME OF DECEASED (Type or print) First <b>KATY</b> Middle <b>D.</b> Last <b>BARBER</b>		4. DATE OF DEATH Month <b>2</b> Day <b>9</b> Year <b>1961</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>AUG. 9, 1870</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>DANIEL DAVIS</b>		14. MOTHER'S MAIDEN NAME <b>DORCAS CARRICK</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>DORCAS HICKOX</b>		Address <b>4508 CHESAPEAKE WASH. D.C.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ABDOMINAL CARCINOMA ETIOLOGY</b> <b>197.1</b> DUE TO <b>UNKNOWN</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>1 YR</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>PARTIAL INTESTINAL OBSTRUCTION + ARTERIOSCLEROTIC HEART DISEASE</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>197</b> to <b>2/9</b> 1961, that (I) (we) lost saw the deceased alive on <b>2/7</b> 1961, and that death occurred on <b>2/9</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Frederick W. Schneider</b> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>FREDERICK W. SCHNEIDER</b>		22d. ADDRESS <b>1024 MASS. AVE NE WASH 2 DC</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/12/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>St Annes CEM.</b>		23d. LOCATION (City, town, or county) (State) <b>Annapolis, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Chung Choo Jung Home</b>		25a. REC'D BY REGISTRAR <b>DATE FEB 14 '61</b>	
ADDRESS <b>5103 WIS Ave NW Wash. DC</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hanna</b>	

7305



2026

VS. A15ME  
5M 7/59

MEDICAL CERTIFICATION

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN lb <u>16 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>10420 Pastured Ave</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>110420 Eastwood Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Lola Collins Batchelor</u> First Middle Last <b>5. SEX</b> <u>Female</u> <b>6. COLOR OR RACE</b> <u>White</u> <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>11-13-1913</u> <b>9. AGE</b> (In years last birthday) <u>47</u> yrs.		<b>4. DATE OF DEATH</b> <u>Feb 6 1961</u> Month Day Year <b>IF UNDER 1 YEAR</b> Months Days <b>IF UNDER 24 HRS.</b> Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>housewife</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>11. BIRTHPLACE</b> (State or foreign country) <u>N.C.</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>		<b>13. FATHER'S NAME</b> <u>Yvonne Cleveland Collins</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Lola Green</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u> <b>16. SOCIAL SECURITY NO.</b> <u>no</u>		<b>17. INFORMANT</b> <u>Mathaniel Batchelor - Sister</u> Address	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Coronary sclerosis</u> (c) <u>Hypertension</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>2 yrs</u> <u>year</u>			
<b>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>. Inspection <input checked="" type="checkbox"/>. Inquiry <input checked="" type="checkbox"/>. and in my opinion death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>2-6-61</u>			
<b>ACTUAL SIGNATURE</b> <u>Frank J. Bloschert</u> <b>EXAMINER'S NAME</b> (Type) <u>FRANK J. Bloschert</u>		<b>DATE SIGNED</b> <b>24a. REC'D BY REGISTRAR</b> <u>Arthur S. Kraus</u> <b>24b. REGISTRAR'S SIGNATURE</b>	
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>2/9/61</u>	
<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Arlington National Cemetery - Arlington, Virginia</u>		<b>22d. LOCATION</b> (City, town, or country) (State)	
<b>23. FUNERAL DIRECTOR</b> <u>The S.H. Hines Co.</u> <u>2901 14th St., N.W.</u> <u>Washington 9, D.C.</u>		<b>24a. REC'D BY REGISTRAR</b> <u>FEB 8 '61</u> <b>24b. REGISTRAR'S SIGNATURE</b>	

0202

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

2027

02003

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>1 hour</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Suburban Hospital</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b> d. STREET ADDRESS <b>4411 Aspen Hill Road</b>			
3. NAME OF DECEASED (Type or print) <b>Clarence William Bauer</b>				4. DATE OF DEATH Month <b>February</b> Day <b>27</b> Year <b>1961</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 14th 1896</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Gilson Art Co.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Ohio</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>PHILLIP BAUER</b>				14. MOTHER'S MAIDEN NAME <b>Mellie Hoessman</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>269-09-8435H</b>		17. INFORMANT (Wife) <b>Mrs. Gretchen Bauer</b>		Address <b>As above</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute coronary thrombosis</b> 4-20-61 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic-hypertensive heart disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>2 1/2 yrs.</b> <b>7 yrs.</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1954</b> to <b>1961</b> that (I) (we) last saw the deceased alive on <b>2/27</b> 19 <b>61</b> , and that death occurred at <b>12:00 AM</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Bernard J. Walsh</b>				22b. DATE SIGNED <b>1961</b>		22c. PHYSICIAN'S NAME (Type) <b>Bernard J. Walsh</b>	
23a. BURIAL, CREMATION, REMOVAL <b>BURIAL</b>		23b. DATE THEREOF <b>3/1/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON NAT'L. CEMETERY</b>		23d. LOCATION (City, town or county) (State) <b>ARLINGTON, VIRGINIA</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>WALTER E. PUMPHREY, INC.</b> <b>Raymond A. Ziska</b>				25a. REC'D BY REGISTRAR DATE <b>MAR 6 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 must be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1916

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with  
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

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2028

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

02004

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b>		c. LENGTH OF STAY IN 1b <b>1 MONTH</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MONTGOMERY GENERAL HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>SHELDON</b> Last <b>BECKER</b>		4. DATE OF DEATH Month <b>FEBRUARY</b> Day <b>6</b> Year <b>19 61</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/15/98</b>
9. AGE (In years lost birthday) <b>62</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>WISCONSIN</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>CHARLES H. BECKER</b>		14. MOTHER'S MAIDEN NAME <b>EMMA PREDDS</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT <b>HOSPITAL RECORDS, OLNEY, MD.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lymphoma, retroperitoneal</b> 202.1 DUE TO <b>with generalized metastasis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH <b>6 mo.</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Sept. 1960</b> to <b>Feb. 6, 1961</b> , that (I) <del>was</del> last saw the deceased alive on <b>Feb. 5, 1961</b> , and that death occurred at <b>3:54 P.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>A. F. Woodward</b>		22b. DATE SIGNED <b>2/6/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>A. F. WOODWARD, M. D.</b>		22d. ADDRESS <b>ROCKVILLE, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2-8-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Forest Oak</b>		23d. LOCATION (City, town, or county) (State) <b>Gaithersburg, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Ernest C. Gartner.</b>		25a. REC'D BY REGISTRAR <b>Gaithersburg, Md.</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kenna</b>		DATE <b>FEB 9 '61</b>	

9028

CERTIFICATE OF DEATH

STATE OF MARYLAND  
DEPARTMENT OF HEALTH

MONTGOMERY

MARYLAND

MONTGOMERY

FARMINGTON GROVE

1 MONTH

1945

MONTGOMERY GENERAL HOSPITAL

DECEMBER 8

CHARLES H. BECKER

WILLIAM

63

WHITE

WHITE

AGE

MONTGOMERY

U.S.A.

CHARLES H. BECKER

CHARLES H. BECKER

HOSPITAL RECORDS, MONTGOMERY, MD.

MONTGOMERY, MD.

MONTGOMERY, MD.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2029

Items 8 &amp; 9, Film G-282 3/2/61.cac

Reg. Dist. No. 02005

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>17</u> years			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. San &amp; Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Vernon</u> Last <u>Bell</u>				4. DATE OF DEATH Month <u>1</u> Day <u>11</u> Year <u>1961</u>			
5. SEX <u>M.</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-29-1879</u>	
9. AGE (In years last birthday) <u>81 1/2</u> yrs.		IF UNDER 1 YEAR Months <u>1</u> Days <u>11</u>		IF UNDER 24 HRS. Hours <u>1</u> Min. <u>1</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Labour</u>		11. BIRTHPLACE (State or foreign country) <u>N. Carolina</u>	
13. FATHER'S NAME <u>Not available</u>				14. MOTHER'S MAIDEN NAME <u>Not available</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>James Edward Bell, (same as #2)</u> Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State) <u></u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb 14, 1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Grove Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>New Bern North Carolina</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Wallers, 254 Carroll St NW DC</u>				24a. REC'D BY REGISTRAR <u>FEB 14 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanna</u>	

MEDICAL CERTIFICATION

2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

[illegible]

UNITED STATES DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

2030

02006

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Florida</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>69 Days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Miami</b>	
3. NAME OF DECEASED (Type or print) <b>Robert</b> First <b>Wit</b> Middle <b>Whitfield</b> Last <b>Bennett Jr.</b>		4. DATE OF DEATH <b>February</b> Month <b>12</b> Day <b>19</b> Year <b>61</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 19, 1913</b>
9. AGE (In years lost birthday) <b>47</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Motel Manager</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Motel</b>	
11. BIRTHPLACE (State or foreign country) <b>Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Robert W. Bennett, Sr.</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Biener</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>Unascertainable</b>	
17. INFORMANT <b>The Medical Records</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Choriocarcinoma</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>December 5, 1960</b> to <b>February 12, 1961</b> , that (I) (we) last saw the deceased alive on <b>February 12, 1961</b> and that death occurred at <b>6:35 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Wendell F. Rosse</b> 6		22b. DATE SIGNED <b>2-12-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Wendell Rosse</b> M.D.		22d. ADDRESS <b>The Clinical Center National Institutes Of Health Bethesda 14, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-Trans</b>		23b. DATE THEREOF <b>2/13/61</b>	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State) <b>Miami Florida</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert Q. Pumphrey</b>		25a. REC'D BY REGISTRAR <b>Bethesda, Maryland</b> 25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

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3030

CERTIFICATE OF DEATH

1. Name of deceased: [illegible]  
2. Sex: [illegible]  
3. Age: [illegible]  
4. Date of birth: [illegible]  
5. Date of death: [illegible]  
6. Place of death: [illegible]  
7. Cause of death: [illegible]  
8. Signature of physician: [illegible]  
9. Signature of registrar: [illegible]  
10. Date of registration: [illegible]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 2031. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

FOR STATE  
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
2031 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02007

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>M</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>8 min</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Wash San &amp; Hosp</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>14 Silver Spring</u> d. STREET ADDRESS <u>2825 Briggs Chase</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Julian Ann Berry Sr</u> First Middle Last 4. DATE OF DEATH <u>2-18-61</u> Month Day Year		5. SEX <u>m</u> 6. COLOR OR RACE <u>w</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>6-3-00</u> 9. AGE (In years last birthday) <u>60</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Milk Prod</u> 11. BIRTHPLACE (State or foreign country) <u>Kentucky</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Samuel William Berry</u>		14. MOTHER'S MAIDEN NAME <u>Pallie Hughes</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>Julian A. Berry Jr - Syme</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>825X</u> <u>Asphyxia due to massive pulmonary edema</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>Myocardial infarction, old.</u> (c) <u>Automobile accident</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>Years.</u> <u>Immediate</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto accident</u>	
20c. TIME OF INJURY Month, Day, Year <u>10:45 pm</u> <u>2-18-61</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> et work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>highway</u> 20f. (City or town) <u>Silver Spring Monty Md</u> (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>2-18-61</u>	
22a. BURNAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>Feb 21-1961</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Marys Episcopal Ch.</u>		22d. LOCATION (City, town, or county) <u>Fairhead - Montgo Co Md.</u> (State)	
23. FUNERAL DIRECTOR <u>Arthur P. Waters, Jr.</u> ADDRESS <u>2500 ARELLA ST.</u>		24a. REC'D BY REGISTRAR <u>FEB 23 '61</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur E. Hines</u>	

1911

1911





TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

2032

**MARYLAND**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

02068

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>1 1/2 da.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> d. STREET ADDRESS <u>5415 Lambeth Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Alfred X. Bisset</u>		<b>4. DATE OF DEATH</b> Month <u>Feb.</u> Day <u>19</u> Year <u>1961</u>		<b>5. SEX</b> <u>Male</u>			
<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>10-8-1900</u> 9. AGE (In years last birthday) <u>60</u> yrs. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Engineer</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Power Co.</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>D. C.</u>			
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.</u>		<b>13. FATHER'S NAME</b> <u>Peter Bisset</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Marie Anderson</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>577-05-0286</u>		<b>17. INFORMANT</b> <u>Helen S. Bisset-Wife-same 2d</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Infarction</u> DUE TO <u>332x</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>Cerebral Thrombosis</u> DUE TO (c) <u>Cerebral arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>  </u>							
<b>19. INTERVAL BETWEEN ONSET AND DEATH</b> <u>36 hrs</u> <u>36 hrs</u> <u>Indefinite</u>							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>  </u>			
<b>20f. (City or town)</b> <u>  </u>		<b>20g. (County)</b> <u>  </u>		<b>20h. (State)</b> <u>  </u>			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>2/12/61</u> , <b>to</b> <u>2/19/61</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>2/19/61</u> , <b>and that death occurred at</b> <u>7:20 p.m.</u> <b>on the date stated above.</b>							
<b>22a. SIGNATURE</b> <u>Stephen N. Jones M.D.</u>		<b>22b. DATE SIGNED</b> <u>2/19/61</u>		<b>22c. PHYSICIAN'S NAME</b> (Type) <u>Stephen N. Jones</u>			
<b>22d. ADDRESS</b> <u>Rockville Medical Center, Rockville</u>		<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>					
<b>23b. DATE THEREOF</b> <u>2/22/61</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Parklawn Cemetery</u>		<b>23d. LOCATION</b> (City, town or county) <u>Rockville, Maryland</u>			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Robert A. Humphrey</u>		<b>24b. ADDRESS</b> <u>Bethesda, Maryland</u>		<b>25a. REC'D BY REGISTRAR</b> <u>FEB 21 '61</u>			
<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kraus</u>		<b>25c. REGISTRAR'S NAME</b> <u>Arthur S. Kraus</u>					

2038

Montgomery

Baltimore

St. Louis

St. Louis

St. Louis

St. Louis

St. Louis

St. Louis

St. Louis

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St. Louis

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2033

CERTIFICATE OF DEATH

Reg. Dist. No. 02009

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>		c. LENGTH OF STAY IN 1b <u>4 MO.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>		18	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>RAHLS Nursing Home</u>				STREET ADDRESS <u>7611 TAKOMA Ave.</u>			
3. NAME OF DECEASED (Type or print) First <u>Louis</u> Middle <u>Denton</u> Last <u>Bliss</u>				4. DATE OF DEATH Month <u>February</u> Day <u>6</u> Year <u>1961</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 31, 1871</u>	9. AGE (In years lost birthday) <u>89</u> yrs.	IF UNDER 1 YEAR Months <u>6</u> Days <u>18</u> Hours <u>18</u> Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TEACHER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SCHOOL</u>		11. BIRTHPLACE (State or foreign country) <u>Newburgh, New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME <u>Emerson W. Bliss</u>				14. MOTHER'S MAIDEN NAME <u>Sarah P. Denton</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>578-14-6228</u>		17. INFORMANT <u>Lillian I. Ralls</u> Address <u>7420 Maple Ave. Takoma Park, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> <u>491X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>19</u> o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3-1</u> , 19 <u>58</u> , to <u>2-6</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>2-5</u> , 19 <u>61</u> , and that death occurred at <u>1:45 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Arnold McNitt</u>				ADDRESS (Street, city or town, state) <u>1835 Eye St., N.W., Washington, D.C.</u>			
PHYSICIAN'S NAME (Type) <u>Arnold McNitt M.D.</u>				DATE SIGNED			
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Interment</u>		22b. DATE THEREOF <u>Feb. 8, 1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Mausoleum</u>		22d. LOCATION (City, town, or county) (State) <u>Prince George's County, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters</u>				ADDRESS <u>254 Carroll St. N.W.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>	
24a. REC'D BY REGISTRAR <u>Feb 8 '61</u>				DATE			

# MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE

## CERTIFICATE OF DEATH

2013

WILLIAM BROWN

NAME OF DECEASED		WILLIAM BROWN	
AGE		65	
SEX		MALE	
RACE		WHITE	
DATE OF DEATH		JANUARY 15, 2013	
PLACE OF DEATH		HOME	
CAUSE OF DEATH		HEART DISEASE	
MANNER OF DEATH		NATURAL	
SIGNATURE OF PHYSICIAN		[Signature]	
SIGNATURE OF WITNESS		[Signature]	
SIGNATURE OF DECEASED		[Signature]	
SIGNATURE OF NEXT OF KIN		[Signature]	
SIGNATURE OF BURIAL OFFICIAL		[Signature]	
SIGNATURE OF REGISTRAR		[Signature]	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH - BALTIMORE

2034

## CERTIFICATE OF DEATH

Reg. Dist. No. 02010

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Kenwood Pk)</b>				c. LENGTH OF STAY IN 1b <b>59</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>5817 Midhill</b>				d. STREET ADDRESS <b>5817 Midhill</b>			
3. NAME OF DECEASED (Type or print) First <b>Emory</b> Middle <b>H.</b> Last <b>BOGLEY</b>				4. DATE OF DEATH Month <b>February</b> Day <b>3</b> Year <b>19 61</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Apr. 16, 1880</b>	
9. AGE (In years lost birthday) <b>80</b> yrs.		IF UNDER 1 YEAR Months <b>9</b> Days <b>17</b>		IF UNDER 24 HRS. Hours <b></b> Min. <b></b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Attorney</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William Bogley</b>				14. MOTHER'S MAIDEN NAME <b>Catherine Haney</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		INFORMANT Address <b>Mrs. Jennie A. Bogley-wife-Same Item #2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>332x</b> IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> DUE TO (b) <b>Cerebral Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <b>2+ yrs.</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic Heart Disease</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month <b>Feb</b> Day <b>3</b> Year <b>1961</b> Hour <b></b> o. m. <b></b> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>1 Saty 46</b> to <b>3 FEB 1961</b> , that I last saw the deceased alive on <b>3 FEB 1961</b> , and that death occurred at <b>249 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>A. H. Richwine</b> M.D.				ADDRESS (Street, city or town, state) <b>5522 WESTERN AVE 3 FEB</b>			
PHYSICIAN'S NAME (Type) <b>A. H. RICHWINE</b>				DATE SIGNED <b>CHEVY CHASE, MD. 1961</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/6/1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rockville</b>		22d. LOCATION (City, town, or county) (State) <b>Rockville Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>				ADDRESS <b>Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 8 '61</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2024

CERTIFICATE OF DEATH

Bethesda (Hennepin Co.)

Bethesda (Hennepin Co.)

8815 Merrill

8815 Merrill

Female

Female

White

White

William Boyer

William Boyer

Mr. Henry J. Hennepin - wife - June 1911

Charles Hennepin  
Charles Hennepin

Interment in Westwood

July 4, 1911

Attest  
J. H. Hennepin  
J. H. Hennepin

Mar. 1911

Rockville

Rockville

Interment in Westwood



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the name of the deceased, the name of the funeral director, and the name of the funeral home. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the name of the deceased, the name of the funeral director, and the name of the funeral home.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2035

## CERTIFICATE OF DEATH

Reg. Dist. No.

02011

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Mont. P.G.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gaithersburg, Rt. # 2</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TAKOMA PARK 1653.2</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Pleasant View Nursing Home</b>				d. STREET ADDRESS <b>6705 POPLAR AVE.</b>			
3. NAME OF DECEASED (Type or print) First <b>Dolores</b> Middle <b>E.</b> Last <b>Bolden</b>				4. DATE OF DEATH Month <b>Feb</b> Day <b>8</b> Year <b>1961</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct 29</b>	9. AGE (In years last birthday) <b>80</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <b>DC</b>		11. BIRTHPLACE (State or foreign country) <b>US</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>Annais Page</b>				14. MOTHER'S MAIDEN NAME <b>Harriet</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Nursing Home Records Gaithersburg, Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart Failure</b> <b>422.2</b> DUE TO <b>Chronic Myocarditis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Senility</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 60</b> , to <b>Feb 8</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>Feb. 7</b> , 19 <b>61</b> , and that death occurred at <b>5:16 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>108 N. Frederick Ave.</b> DATE SIGNED ACTUAL SIGNATURE <b>Luciano I. Leal</b> PHYSICIAN'S NAME (Type) <b>Luciano I. Leal.</b> <b>Gaithersburg, Md.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>2/11/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>HARMONY MEM. PARK</b>		22d. LOCATION (City, town, or county) (State) <b>MARYLAND</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert L. McGuire</b>				24a. REC'D BY REGISTRAR <b>1820 9th St., N.W.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any person is needed to execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2036 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02012

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>md</i> b. COUNTY <i>montg</i>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		d. STREET ADDRESS <i>4801 North Lane Apt 204</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Eva</i>		4. DATE OF DEATH <i>Feb 25 1961</i>		5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <i>3/19/79</i>		9. AGE (In years last birthday) <i>83</i>		10. IF UNDER 1 YEAR Months <i>11</i> Days <i>6</i> Hours <i></i> Min. <i></i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>----</i>		11. BIRTHPLACE (State or foreign country) <i>Pennsylvania</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>(Unknown) Savidge</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>339-07-0514A</i>		17. INFORMANT <i>Donald E. Bostock, son-</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute myocardial Infarction</i> 420 - 1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hemorrhage into Atheromatous plaque</i> DUE TO (c) <i>Coronary atherosclerosis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>6 hrs</i> <i>6 hrs</i> <i>Unknown</i>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <i>Frank J. Bostock</i>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <i>2-26-61</i>			
EXAMINER'S NAME (Type) <i>FRANK J. BOSTOCK</i>		Address (Street, city, town, or county)		22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>3/1/61</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Parklawn Cemetery</i>		22d. LOCATION (City, town, or country) (State) <i>Rockville, Maryland</i>			
23. FUNERAL DIRECTOR <i>Robert A. Pumphrey</i>		ADDRESS <i>Bethesda, Maryland</i>		24a. REC'D BY REGISTRAR <i>FEB 28 '61</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Knead</i>							

100-1001



Female  
White  
Boston  
Pennyworth

(Unknown)  
25-07-1914 Donald E. Boston, son-  
Unknown

*Handwritten signature: George W. [illegible]*

Robert A. Pomeroy, Registrar  
Boston, Massachusetts

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

2037

02013

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY in 1b <u>15 days</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium &amp; Hospital</u>				d. STREET ADDRESS <u>10008 Sutherland Rd.</u>			
3. NAME OF DECEASED (Type or print) <u>Harold Leopold Bradford</u>				4. DATE OF DEATH <u>February 4 1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Cauc.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-21-84</u>	
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done (last 12 mos. of working life, even if retired) <u>Md. Nat'l Park &amp; Planning Comm. Planning Commission</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>John L. Bradford</u>			
14. MOTHER'S MAIDEN NAME <u>Emma Wert</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service)			
16. SOCIAL SECURITY NO. <u>578-07-2930</u>				17. INFORMANT Address <u>Patient - Mr. Harold Bradford</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>ASPIRATION OF GASTRIC CONTENT K.R.N.</u> <u>CHRONIC THROMBOSIS</u> <u>540.0</u> DUE TO <u>ULCERS, GASTRIC AND DUODENAL, PEPTIC (5) K.R.N.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>WITH (b) GENERALIZED ARTERIOSCLEROSIS</u> <u>(c) PULMONARY ATELECTASIS AND RESOLVING PNEUMONIA K.R.N.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fx L HIP</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>IMMEDIATE</u> <u>WEEKS K.R.N.</u> <u>50 YEARS</u> <u>DAYS K.R.N.</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>FELL AT WORK 1/18/61</u>							
20c. TIME OF INJURY Month, Day, Year <u>1/18 19 61</u>		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>PARK PLANNING COMM</u>		20f. (City or town) <u>SS</u> (County) <u>MONTGOMERY</u> (State) <u>MD</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>1/18/61</u> , 19 <u>  </u> , to <u>2/4/61</u> , 19 <u>  </u> , that (I) (we) last saw the deceased alive on <u>2/3/61</u> , 19 <u>  </u> , and that death occurred at <u>3:25 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>G. Rivatmo</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>GEORGE L RIVAT MD</u>				22d. ADDRESS <u>10620 Georgia Ave., S.S., MD</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>2/8/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>COLESVILLE CEMETERY</u>		23d. LOCATION (City, town or county) (State) <u>MONTGOMERY COUNTY, MARYLAND</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Ziska</u> INC. ADDRESS <u>SILVER SPRING, MD.</u>				25a. REC'D BY REGISTRAR <u>FEB 10 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

02014

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Marilea Rest Home</b>		d. STREET ADDRESS <b>4869 Battery Lane</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Florence Bailey Bradley</b>		4. DATE OF DEATH Month Day Year <b>Feb. 14 1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/10/83</b>
9. AGE (In years last birthday) yrs. <b>77</b>		10. IF UNDER 1 YEAR <b>5</b> Months <b>2</b> Days <b>19</b> Hours <b>5</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Charles E. Bailey</b>		14. MOTHER'S MAIDEN NAME <b>Ida Jewell</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. Donald Deane, daughter-same 2d</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO <b>331X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 1, 1950</b> to <b>Feb 14, 1961</b> that I last saw the deceased alive on <b>2-13-61</b> and that death occurred at <b>1:30 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>John S. Rogers, M.D.</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>1719 Seminary Rd., Silver Spring, Md. 20906</b>	
PHYSICIAN'S NAME (Type) <b>John S. Rogers, M. D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2/16/61</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Rockville, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		ADDRESS <b>Bethesda, Maryland</b>	
24a. REC'D BY REGISTRAR <b>FEB 17 1961</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

02015

2039

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>				c. LENGTH OF STAY IN 1b <b>-</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Washington Sanitarium &amp; Hospital</b>				d. STREET ADDRESS <b>9607 Telegraph Rd.</b>			
3. NAME OF DECEASED (Type or print) <b>Josephine Ruth Brennan</b>				DATE OF DEATH <b>FEB 22 1961</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 14 - 1919</b>	
9. AGE (In years last birthday) <b>41</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>At home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Washington, D.C.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>Amer. U.S.</b>							
13. FATHER'S NAME <b>David Baumbach</b>				14. MOTHER'S MAIDEN NAME <b>Josephine Bauerline</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>			
17. INFORMANT <b>Mr. David E. Brennan,</b>				Address <b>9607 Telegraph Road, Lanham, Maryland.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic carcinoma to the liver</b> 171X DUE TO (b) <b>Primary carcinoma of the cervix (operated)</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <b>6 years</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
MEDICAL CERTIFICATION							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 21, 1961</b> to <b>Febr 22, 1961</b> ; that (I) (we) last saw the deceased alive on <b>Febr. 22, 1961</b> , and that death occurred at <b>12:5 PM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Eino Magi</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>2/22/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>EINO MAGI</b>				22d. ADDRESS <b>918 Univ. Blvd. E., Silver Spring, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Feb. 24, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Bladensburg, Maryland.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. W. CHAMBERS CO</b>				ADDRESS <b>RIVERDALE, MD</b>		25a. REC'D BY REGISTRAR <b>DATE FEB 27 '61</b>	
				25b. REGISTRAR'S SIGNATURE <b>Anthony S. Hanna</b>			

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

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Abstract: 1

At home

○

NUMBER 2, 1967

1995

2. *Journal of the American Medical Association*, 1997; 277: 1033-1037.

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The attending physician, the funeral director, or the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

2040

02016

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>WASH.</b> b. COUNTY <b>D.C.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WASH D.C.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Reamor Hospital</b>		d. STREET ADDRESS <b>5084 Lowell St. N.W. W</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Emma</b> First <b>XXXXX</b> Middle <b>X Lena</b> Last <b>Bricker</b>		4. DATE OF DEATH <b>Feb. 11, 1961</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-21-1877</b>
9. AGE (In years lost birthday) <b>83</b> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Wash., D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>NAm United St.</b>	
13. FATHER'S NAME <b>William Breauerscheuter</b>		14. MOTHER'S MAIDEN NAME <b>Harriet Long</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Edwin D. Bricker-Husband</b>		Address <b>same d2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized arteriosclerosis</b> <b>442X</b> DUE TO <b>with cardio vascular renal disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>disiase</b> (c)			INTERVAL BETWEEN ONSET AND DEATH <b>3-4 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Dec. 1955</b> to <b>present</b> , that (I) (we) last saw the deceased alive on <b>2-11-61</b> , and that death occurred at <b>6:00 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>C P Ryland</b>		22b. DATE SIGNED <b>2-11-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>C P RYLAND.</b>		22d. ADDRESS <b>4400-49th St NW Washington DC</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>2/15/61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat. Cem.</b>	23d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia DC</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Humphrey</b>		25a. REC'D BY REGISTRAR <b>FEB 15 '61</b>	
ADDRESS <b>Bethesda, Maryland</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Evans</b>	

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CENTRAL BANK OF DENMARK

RECEIVED BY THE BANK OF DENMARK  
ON THE 10th of JANUARY 1940

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**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

02018

2041

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>D.C.</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>			c. LENGTH OF STAY IN 1b <b>32 hrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban Hospital</b>				d. STREET ADDRESS <b>3333 Runnymede Pl., N.W.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>D.</b> Last <b>Brown</b>				4. DATE OF DEATH Month <b>2</b> Day <b>27</b> Year <b>1961</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>August 6, 1877</b>	
9. AGE (In years last birthday) <b>83</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Thomas Veale</b>				14. MOTHER'S MAIDEN NAME <b>Mary DeBell</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT (Daughter) <b>Elizabeth D. Barnes</b>		Address <b>as above</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>myocardial anoxemia &amp; respiratory failure due to</b> <b>199.2</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Anemia, due malnutrition due to</b> DUE TO (c) <b>Terminal Carcinoma</b> INTERVAL BETWEEN ONSET AND DEATH <b>7 months</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>acute coronary heart failure Hypertension</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. — 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>June 1955</b> to <b>Feb 27, 1961</b> , that (I) <del>was</del> last saw the deceased alive on <b>Feb 26, 1961</b> , and that death occurred at <b>1:15 AM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Margaret E. Callan</b>				22b. DATE SIGNED <b>2-27-61</b>		22c. PHYSICIAN'S NAME (Type) <b>Margaret E. Callan</b>	
22d. ADDRESS <b>4700 Bradley Blvd. Chevy Chase, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>12/2/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rock Creek Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Washington, D.C.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>2501-14th St. N.W. Wash, D.C.</b>				25a. REC'D BY REGISTRAR DATE <b>MAR 1 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

STATE OF TEXAS  
COUNTY OF DALLAS

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W. A. W.

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**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

02019

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN lb <u>5 months</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Oakhaven Convalescent Home</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Colmar Manor</u> d. STREET ADDRESS <u>3907 Newton St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Hamilton</u> Middle <u>Bryden</u> Last <u>Bryden</u>				<b>4. DATE OF DEATH</b> Month <u>Feb</u> Day <u>12</u> Year <u>1961</u>									
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec 6 1878</u>		9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u> IF UNDER 24 HRS. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>				11. BIRTHPLACE (State or foreign country) <u>Scotland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>Hamilton Bryden</u>						14. MOTHER'S MAIDEN NAME <u>Jane Hall</u>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>  </u>				17. INFORMANT <u>Mrs Edward Gorman</u> Address <u>  </u>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> 334 X DUE TO <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>  </u> DUE TO <u>  </u> (c) <u>  </u>										INTERVAL BETWEEN ONSET AND DEATH <u>  </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>									
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>61</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) <u>  </u> (County) <u>  </u> (State) <u>  </u>					
21. I certify that (I) (this hospital) attended the deceased from <u>12/6</u> 19 <u>60</u> to <u>2/12</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>2/8</u> 19 <u>61</u> , and that death occurred at <u>  </u> M, from the causes and on the date stated above.													
22a. SIGNATURE <u>  </u>						22b. DATE SIGNED <u>  </u>							
22c. PHYSICIAN'S NAME (Type) <u>B. M. Holston</u>						22d. ADDRESS <u>Washington Sanitarium, Takoma Park, Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>2-16-1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>FORT LINCOLN</u>		23d. LOCATION (City, town, or county) (State) <u>Bladensburg, Maryland</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers Co</u> ADDRESS <u>Riverdale, Md</u>						25a. REC'D BY REGISTRAR <u>  </u> DATE <u>1 4 '61</u>		25b. REGISTRAR'S SIGNATURE <u>  </u>					



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

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2043  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
02020

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>M</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>18 Days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Florida</b> <b>48 X-3</b> b. COUNTY <b>Daytona Beach</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Daytona Beach</b> d. STREET ADDRESS <b>3920 Oriole Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>Stella</b> Middle <b>Annice</b> Last <b>Buchs</b>			4. DATE OF DEATH Month <b>February</b> Day <b>14</b> Year <b>19 61</b>		
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>May 18, 1907</b>		9. AGE (In years last birthday) <b>53</b> yrs.		10. IF UNDER 1 YEAR Months <b>53</b> Days <b>14</b> Hours <b>14</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Hostess</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Restaurant</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Leonard Hudson</b>		14. MOTHER'S MAIDEN NAME <b>Matilda Jane King</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Not available</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrhythmia and Arrest</b> DUE TO <b>Diffuse non-specific metabolic abnormalities</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>extensive carcinoma of palate</b> (b) <b>several weeks</b> (c) <b>months</b>		INTERVAL BETWEEN ONSET AND DEATH <b>15 min.</b>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Severe diabetes mellitus</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					

21. I certify that (I) (this hospital) attended the deceased from **January 27, 1961** to **February 14, 1961**, that (I) (we) last saw the deceased alive on **Feb. 14, 1961**, and that death occurred at **2:45 a.m.**, from the causes and on the date stated above.

22a. SIGNATURE <b>David J. Crawford MD</b>		22b. DATE SIGNED <b>2/15/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>DAVID T. CRAWFORD, M.D.</b>		22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Maryland</b>	

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/17/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery Prince Georges County, Md.</b>		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines company-</b>		ADDRESS <b>2901 14th St., N.W.</b>		25a. REC'D BY REGISTRAR <b>Washingt 9, D.C.</b>		25b. REGISTRAR'S SIGNATURE <b>Carling L. Kline</b>	

CERTIFICATE OF DEATH

5043

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Paul J. Crawford MD



## CERTIFICATE OF DEATH

Reg. Dist. No. 2025

MEDICAL CERTIFICATION	1. PLACE OF DEATH a. COUNTY <b>Montg</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montg</b>			
	b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Boys</b>		c. LENGTH OF STAY IN 1b <b>90Yrs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Boys</b>			
	d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <b>J R F D</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
	3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Darby</b> Last <b>Burdette</b>				4. DATE OF DEATH Month <b>Feb</b> Day <b>17</b> Year <b>1961</b>			
	5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov 13-1870</b>	
	9. AGE (In years lost birthday) <b>90</b> yrs.		IF UNDER 1 YEAR Months <b>3</b> Days <b>4</b> Hours <b></b> Min. <b></b>		IF UNDER 24 HRS. Months <b></b> Days <b></b> Hours <b></b> Min. <b></b>			
	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>		11. BIRTHPLACE (State or foreign country) <b>Boys, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
	13. FATHER'S NAME <b>William Burdette</b>				14. MOTHER'S MAIDEN NAME <b>Martha Shipley</b>			
	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		INFORMANT <b>Kenneth Burdette, Boys, Md.</b>			
	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		Address <b>Kenneth Burdette, Boys, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>334X</b> IMMEDIATE CAUSE (a) <b>Malnutrition</b> DUE TO (b) <b>Senile Psychosis</b> DUE TO (c) <b>Generalized Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. INTERVAL BETWEEN ONSET AND DEATH <b>3 months</b> <b>2 years</b> <b>15 years</b>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour <b>a. m.</b> Month <b>19</b> Day <b></b> Year <b></b> p. m. <b></b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Nat while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>Oct 1952</b> , to <b>17 Feb 1961</b> , that I last saw the deceased alive on <b>17 Feb 1961</b> , and that death occurred at <b>8 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Barnesville, Md</b> DATE SIGNED <b>18 Feb 61</b> ACTUAL SIGNATURE <b>John M Smith</b> M.D. <b></b> PHYSICIAN'S NAME (Type) <b></b>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2-20-61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Boys Church Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Boys, Maryland</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ernest C. Gartner. Gaithersburg. MD</b>				24a. REC'D BY REGISTRAR DATE <b>FEB 21 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. K...</b>		

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

2045

02022

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Pennsylvania</b> b. COUNTY <b>Pittsburgh 17</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>4 Days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Marian Myrtle Burgess</b>		4. DATE OF DEATH <b>February 2, 19 61</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 3, 1918</b>
9. AGE (In years last birthday) <b>42 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Fleming Shaw</b>		14. MOTHER'S MAIDEN NAME <b>Myrtle Mitts</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Not Available</b>	
17. INFORMANT <b>The Medical Record</b>		Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive intrathoracic &amp; gastrointestinal hemorrhage</b> DUE TO (b) <b>Bilateral total atelectasis</b> DUE TO (c) <b>Aortic and Mitral stenosis</b> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b> 20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from <b>January 29, 19 61</b> to <b>February 2, 19 61</b> , that (I) (we) last saw the deceased alive on <b>February 2, 19 61</b> , and that death occurred at <b>9:25 a.m.</b> , from the causes and on the date stated above. 22a. SIGNATURE <b>A. G. Morrow</b> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) <b>A. G. Morrow, M.D.</b> 22b. DATE SIGNED <b>2/2/61</b> 23a. BURIAL, CREMATION, REMOVAL, or SPECIFY <b>Burial-transit 2-2-61</b> 23b. DATE THEREOF <b>2-2-61</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b> 23d. LOCATION (City, town, or county) (State) <b>Allegheny County, Penna.</b> 24. FUNERAL DIRECTOR'S SIGNATURE <b>ROBERT A. PUMPHREY</b> ADDRESS <b>Bethesda, Md.</b> 25a. REC'D BY REGISTRAR <b>FEB 6 '61</b> 25b. REGISTRAR'S SIGNATURE <b>G. S. Pumphrey</b>			

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CERTIFICATE OF QUALITY

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TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

(I)

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
2046 CERTIFICATE OF DEATH 02023											
1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEORGES</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TAKOMA PARK</b>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RIVERDALE</b>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>WASHINGTON SANITARIUM + HOSPITAL</b>						d. STREET ADDRESS <b>4705 Oliver Street</b>					
3. NAME OF DECEASED (Type or print) First <b>LENA</b> Middle <b>LOUISE</b> Last <b>BUSHBY</b>						4. DATE OF DEATH Month <b>FEB.</b> Day <b>14</b> Year <b>1961</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1-15-78</b>		9. AGE (In years last birthday) <b>83 yrs.</b>		IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>D.C.</b>				12. CITIZEN OF WHAT COUNTRY? <b>American</b>	
13. FATHER'S NAME <b>CHARLES HARTMAN</b>						14. MOTHER'S MAIDEN NAME <b>EMMA UNKNOWN</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>HOSPITAL RECORD</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Hypertension</b> (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>One day</b> <b>Unknown</b>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>2/4/61 face released by Broschart - Corner</b>							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Washington</b>		20g. (County) <b>D.C.</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>2/13/61</b> , <b>1961</b> , to <b>2/14</b> , <b>1961</b> , that (I) (we) last saw the deceased alive on <b>2-13-1961</b> , and that death occurred <b>2:35 AM</b> , from the causes and on the date stated above.											
22a. SIGNATURE <b>Robert A. Hare M.D.</b>						22b. DATE SIGNED <b>2/14/61</b>					
22c. PHYSICIAN'S NAME (Type) <b>Robert A. Hare M.D.</b>						22d. ADDRESS <b>7600 Carroll Ave., T.P. Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>				23b. DATE THEREOF <b>2/16/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>GLENWOOD CEMETERY</b>				23d. LOCATION (City, town or county) (State) <b>WASHINGTON, D.C.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond A. Buska</b>						ADDRESS <b>SILVER SPRING, MD.</b>		25a. REC'D BY REGISTRAR <b>FEB 20 '61</b>		25b. REGISTRAR'S SIGNATURE <b>William S. Kraus</b>	

2010

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Robert A. Hare MD

2010



TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Pages may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH															
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND															
2047 CERTIFICATE OF DEATH															
02024															
1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>TAKOMA PARK</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>OAK HAVEN CONVALESCENT HOME</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Illinois</b> b. COUNTY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Peoria</b> d. STREET ADDRESS <b>500 N. Madison Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <b>JEAN</b>			First <b>M</b> Middle <b>CALDWELL</b> Last			4. DATE OF DEATH <b>FEB 12 19 61</b>			Month <b>FEB</b> Day <b>12</b> Year <b>19 61</b>						
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9/10/1872</b>		9. AGE (In years last birthday) <b>88</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Secretary</b>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <b>Indiana</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>David Caldwell</b>						14. MOTHER'S MAIDEN NAME <b>Mary Donahue</b>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>357-03-6072</b>		17. INFORMANT <b>David Caldwell</b>		Address <b>Arlington, Va. 4226 Columbia Pike,</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Congestive Failure</b> <b>450</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Arteriosclerosis</b> (c) DUE TO (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Hour <b>19</b> e.m. p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>12/11</b> , 19 <b>60</b> to <b>2/11</b> , 19 <b>61</b> that (I) (we) last saw the deceased alive on <b>2/14</b> , 19 <b>61</b> , and that death occurred at <b>11</b> M, from the causes and on the date stated above.															
22a. SIGNATURE <b>CH Hobbs</b>						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED						
22c. PHYSICIAN'S NAME (Type) <b>CH Hobbs</b>						22d. ADDRESS <b>7401 Blue Rd Ark</b>									
23a. <del>BURIAL</del> CREMATION REMOVAL (Specify) <b>2/14/61</b>				23b. DATE THEREOF				23c. NAME OF CEMETERY OR CREMATORY <b>Springdale Cemetery</b>				23d. LOCATION (City, town or county) (State) <b>Peoria, Illinois</b>			
24 FUNERAL DIRECTOR'S SIGNATURE <b>The S.H.Hines Co., 2901 14th St. N.W.</b>						ADDRESS <b>Wash, DC</b>		25a. REC'D BY REGISTRAR <b>FEB 14 61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>					

1947

MEMORANDUM

TO: SAC, NEW YORK

FROM: SAC, NEW YORK (100-100000)

SUBJECT:

RE: [illegible]

Reference is made to

your letter of 1/11/47

and

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

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2018  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

02025  
47X-3

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda Md.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington D.C.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Resmor Sanat Hospital</i>		d. STREET ADDRESS <i>Apt. 404 G, 2500 Calvert St., N.W.</i>	
3. NAME OF DECEASED (Type or print) <i>George</i> First <i>Boone</i> Middle <i>Carpenter</i> Last		4. DATE OF DEATH <i>Feb. 14</i> 19 <i>61</i> Year	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 7, 1877</i>
9. AGE (In years <i>83</i> yrs. <i>83</i> yrs.)		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Rancher</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>	
11. BIRTHPLACE (State or foreign country) <i>United States ?</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S.</i>	
13. FATHER'S NAME <i>George B. Carpenter</i>		14. MOTHER'S MAIDEN NAME <i>Fula Boone</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>Unknown</i>	
17. INFORMANT <i>Mrs. George Carpenter wife</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Bronchopneumonia</i> DUE TO <i>491X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>—</i> DUE TO (c) <i>—</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>generalized arteriosclerosis</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>April 24, 1960</i> to <i>Feb 14, 1961</i> , that (I) (we) last saw the deceased alive on <i>Feb. 14, 1961</i> , and that death occurred at <i>11:30 PM</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>Wilfred R. Ehrmontraut</i> M.D.		22b. ADDRESS <i>Bethesda, Md.</i>	
22c. PHYSICIAN'S NAME (Type) <i>Wilfred R. Ehrmontraut M.D.</i>		22d. ADDRESS <i>4890 Battery Lane</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		23b. DATE THEREOF <i>2/15/61</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Crematory</i>		23d. LOCATION (City, town or county) (State) <i>Suitland, Maryland</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey</i>		25a. REC'D BY REGISTRAR <i>FEB 17 '61</i> DATE	
25b. REGISTRAR'S SIGNATURE <i>Arthur S. Thaus</i>			

*[Faint, mostly illegible text, likely bleed-through from the reverse side of the document. The text appears to be a narrative or medical history.]*

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/60

2051193XV0-21 P. Palmer

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2049

## CERTIFICATE OF DEATH

02026

<b>1. PLACE OF DEATH</b> a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 2 hrs. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital			<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission) a. STATE District of Columbia b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 643 K Street, N.E. d. STREET ADDRESS 643 K Street, N.E. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last FEMALE Negro 5. SEX 6. COLOR OR RACE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 2-21-61 9. AGE (In years last birthday) 2 yrs. 10. BIRTHPLACE (County & State, or foreign country) Maryland 11. CITIZEN OF WHAT COUNTRY? USA 12. DATE OF DEATH February 21 19 61 13. FATHER'S NAME Stanley W. CARTER 14. MOTHER'S MAIDEN NAME Shirley Ann BAILEY 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. None 17. INFORMANT (F) Stanley W. Carter, same as #2 above Address					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 762-5 DUE TO IMMATURITY (b) ATELECTASIS, CONGENITAL (c) DUE TO CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (his/her) attended the deceased from Feb. 21 1961 to Feb. 21 1961, that (I) (we) saw the deceased alive on Feb. 21 1961, and that death occurred at 11PM, from the causes and on the date stated above. 22a. SIGNATURE Fred W. Grello M.D. 22b. DATE SIGNED 2-22-61 22c. PHYSICIAN'S NAME (Type) Fred W. GRELLO, LT, MC, USN 22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 2-25-61 23c. NAME OF CEMETERY OR CREMATORY National Harmony Memorial Pk. 23d. LOCATION (City, town or county) (State) Prince George, Maryland 24. FUNERAL DIRECTOR'S SIGNATURE Palmer Funeral Home, 412 H St., NE, WashDC 25a. REC'D BY REGISTRAR DATE FEB 27 '61 25b. REGISTRAR'S SIGNATURE Arthur S. Evans					





TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any of the pages are necessary, they should be retained for your file. Please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

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FOR STATE  
HEALTH DEPT.

(M)

(I)

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH														
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
MEDICAL EXAMINER'S CERTIFICATE OF DEATH														
02027														
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u> c. LENGTH OF STAY IN 1b <u>20 YEARS</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>12 Deer Park Drive</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u> d. STREET ADDRESS <u>12 Deer Park Dr</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <u>John S Carter</u>					4. DATE OF DEATH <u>Feb 2 1961</u>									
5. SEX <u>male</u>					6. COLOR OR RACE <u>white</u>									
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH <u>4-26-1895</u>									
9. AGE (In years last birthday) <u>65</u> yrs.					10. IF UNDER 1 YEAR Months Days									
11. IF UNDER 24 HRS. Hours Min.					12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>									
13. FATHER'S NAME <u>John Franklin Carter</u>					14. MOTHER'S MAIDEN NAME <u>Annie E. Damude</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>					16. SOCIAL SECURITY NO. <u>unknown</u>									
17. INFORMANT <u>Elizabeth A. Dove</u>					Address <u>Gaithersburg, Md.</u>									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <u>420.1 Coronary occlusion</u> DUE TO (b) <u>sudden</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>420.1</u> DUE TO (c) <u>420.1</u>										INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>					20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>									
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)									
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE <u>Frank J. Broschart</u>					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>									
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>2-2-61</u>									
Address (Street, city, town, or county)														
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					22b. DATE THEREOF <u>2-4-61</u>									
22c. NAME OF CEMETERY OR CREMATORY <u>Forest Oak</u>					22d. LOCATION (City, town, or country) (State) <u>Gaithersburg, Md.</u>									
23. FUNERAL DIRECTOR <u>Francis J. Barber</u>					ADDRESS <u>Eatonville, Md.</u>									
24a. REC'D BY REGISTRAR <u>FEB 6 '61</u>					24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>									

5056

Anna E. Brand

John Brand

Alfred B. Brand

Unknown

1

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any of the following is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

1  
FOR STATE  
HEALTH DEPT.

(M)

(I)

MEDICAL CERTIFICATION

MAYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
02028											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park D.C.</u> c. LENGTH OF STAY in lb <u>D.O.A</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Wash. SAN + Hosp</u>				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>1206 Hillmoor Drive</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Floyd Mason Carver</u>		First <u>Floyd</u> Middle <u>Mason</u> Last <u>Carver</u>		4. DATE OF DEATH Month <u>2</u> Day <u>3</u> Year <u>1961</u>		5. SEX <u>m</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>11-17-03</u>		9. AGE (In years last birthday) <u>57</u> yrs.		IF UNDER 1 YEAR Months <u>5</u> Days <u>7</u>		IF UNDER 24 HRS. Hours <u>5</u> Min. <u>7</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>			
10b. BUSINESS OR INDUSTRY <u>Bakery</u>				11. BIRTHPLACE (State or foreign country) <u>Wash. D.C.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Richard B. Carver</u>				14. MOTHER'S MAIDEN NAME <u>Florence Henderson</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>577-01-9560</u>				17. INFORMANT <u>Alicecene Carver</u> Address <u>Stones Beach</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>sudden</u> (c) <u>sudden</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>sudden</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				22b. DATE THEREOF <u>2/7/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL CEMETERY</u>		22d. LOCATION (City, town, or country) (State) <u>PRINCE GEO. COUNTY, MARYLAND</u>			
23. FUNERAL DIRECTOR <u>WASNER E. PUMPHREY, INC</u> ADDRESS <u>SILVER SPRING, MD.</u>				24a. REC'D BY REGISTRAR <u>Raymond A. Zucka</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanna</u>		DATE <u>FEB 9 '61</u>			

MASSACHUSETTS DEPARTMENT OF HEALTH  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

100

DEATH  
100

(1)

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

2052

CERTIFICATE OF DEATH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

02029

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>26 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				d. STREET ADDRESS <b>Route # 1, Box 519</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Lottie</b> Middle <b>Elizabeth</b> Last <b>Chapman</b>				4. DATE OF DEATH Month <b>February</b> Day <b>6</b> Year <b>19 61</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>August 30, 1917</b>	
9. AGE (In years lost birthday) <b>43</b> yrs.		IF UNDER 1 YEAR Months <b>43</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>		IF UNDER 24 HRS. Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>James Evand</b>				14. MOTHER'S MAIDEN NAME <b>Etta Parker</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>218-20-6054</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute respiratory insufficiency secondary to pneumonia and atelectasis</b> DUE TO <b>Chronic pulmonary disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Rheumatic heart disease, Mitral Stenosis</b> DUE TO (c) <b>hours</b> <b>years</b> <b>years</b>				INTERVAL BETWEEN ONSET AND DEATH <b>hours</b> <b>years</b> <b>years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>January 11, 1961</b> to <b>February 6, 1961</b> , that (I) (we) last saw the deceased alive on <b>February 6, 1961</b> , and that death occurred on <b>2:28PM</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>James L. Talbert</b>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>2/6/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>James L. Talbert, M.D.</b>				22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>			
23a. BURIAL <b>EXEMPTED</b>		23b. DATE THEREOF <b>2-10-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sunnyridge Cem</b>		23d. LOCATION (City, town, or county) (State) <b>Hopewell, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Bradshaw &amp; Sons Main St. Crisfield, Md.</b>				ADDRESS <b>Crisfield, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>FEB 9 '61</b>	
						25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

2052

CERTIFICATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

RELIGION

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2053

CERTIFICATE OF DEATH

02030

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SUBURBAN HOSPITAL</b>				d. STREET ADDRESS <b>16 GLENMONT ROAD</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>HELEN</b> Middle <b>FAWCETT</b> Last <b>CISSEL</b>				4. DATE OF DEATH Month <b>FEB.</b> Day <b>12</b> Year <b>1961</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan. 31, 1885</b>	
9. AGE (In years lost birthday) <b>76</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOMEMAKER</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		11. BIRTHPLACE (State or foreign country) <b>MONTGOMERY COUNTY, MD.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>LLOYD FAWCETT</b>				14. MOTHER'S MAIDEN NAME <b>ELLA MARLOW</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>				16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT Address <b>Mr. Truman R. Cissel, 16 Glenmont Rd. Colesville, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute Myocardial infarction</b> 420.1 DUE TO <b>Rupture-atheromatous Plaque and Coronary artery</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Generalized Arterio Sclerosis</b> DUE TO <b>Many years</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>4 hours</b> <b>4 hours</b> <b>Many years</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Silver Spring, Maryland</b>				(County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>March 1950</b> to <b>Feb-12 1961</b> , that (I) (we) last saw the deceased alive on <b>Feb-12 1961</b> , and that death occurred at <b>11:58 AM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Merrill M. Cross</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>2/13/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>MERRILL M. CROSS</b>				22d. ADDRESS <b>8248 Meggin Ave. Silver Spring, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>				23b. DATE THEREOF <b>2/15/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Mark's Epis. Church Cemetery</b>	
23d. LOCATION (City, town, or county) <b>Fairland, Montgomery Co., Md.</b>				(State)			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond A. Giska</b>				ADDRESS <b>SILVER SPRING, MD.</b>		25a. REC'D BY REGISTRAR DATE <b>FEB 16 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kinn</b>							

1. Name of deceased: *John Doe*  
2. Sex: *Male*  
3. Age: *45*  
4. Date of birth: *Jan 15, 1906*  
5. Date of death: *Dec 10, 1951*  
6. Place of death: *Home*  
7. Cause of death: *Heart disease*  
8. Signature of physician: *John Doe*  
9. Signature of registrar: *John Doe*  
10. Signature of informant: *John Doe*

Page 4 of 4  
TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death by the attending physician or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

02031

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b>		c. LENGTH OF STAY IN 1b <b>15 DAYS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MONTGOMERY GENERAL HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JAMES</b> Middle <b>URIAH</b> Last <b>CLAGGETT</b>		4. DATE OF DEATH Month <b>FEBRUARY</b> Day <b>23</b> Year <b>19 61</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>COLORED</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-15-1891</b>
9. AGE (In years lost birthday) <b>69</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED LABORER</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>MARSHALL CLAGGETT</b>		14. MOTHER'S MAIDEN NAME <b>LEANNA WALLACE</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>HOSPITAL RECORDS, OLNEY, MARYLAND</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Embolism</b> 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma of Pancreas</b> DUE TO (c) <b>2 months</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Surgery 1 wk prior to death.</b> INTERVAL BETWEEN ONSET AND DEATH <b>1 hr.</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Feb 4</b> 19 <b>61</b> to <b>Feb 23</b> 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>Feb 23</b> 19 <b>61</b> , and that death occurred at <b>3:00</b> P.M. from the causes and on the date stated above.			
22a. SIGNATURE <b>Richard A. Yates, M.D.</b>		22b. DATE SIGNED <b>2-24-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>R. A. YATES, M. D.</b>		22d. ADDRESS <b>OLNEY, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/26/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Ash Memorial Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Sandy Spring, Md</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert L. Shawler</b>		25a. REC'D BY REGISTRAR <b>Rockwell, Md</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>		DATE <b>FEB 28 '61</b>	

CERTIFICATE OF DEATH

5151

DATE OF DEATH

TIME

PLACE

AGE

CAUSE OF DEATH

REPORTED BY

DATE

SEX

EDUCATION

RELIGION

OCCUPATION

STATUS

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

TIME

PLACE

Page 4  
TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
ISM 9/59

2055

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

02032

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4857 BATTERY LANE</u>				d. STREET ADDRESS <u>4857 BATTERY LANE</u>			
3. NAME OF DECEASED (Type or print) <u>STANLEY MARQUYS CLANCEY</u>				4. DATE OF DEATH <u>Feb. 21</u> 19 <u>61</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>APR 22 1887</u>	
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALES MAN</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Railway Supplies</u>			
11. BIRTHPLACE (State or foreign country) <u>ILLINOIS</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>MARK CLANCEY</u>				14. MOTHER'S MAIDEN NAME <u>NELL MULLIN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>106-111-1111</u>			
17. INFORMANT <u>WIFE</u> Address <u>SAME - 2 D</u>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Floor of Mouth</u> <u>143X</u> DUE TO <u>&amp; metastases</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypostatic Pneumonia</u> (c) <u>@ 1 wk</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>June 19 60</u> to <u>February 19 61</u> , that (I) ( <u>we</u> ) last saw the deceased alive on <u>2-18 1961</u> , and that death occurred at <u>1:43 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Bernard A Fitzgerald</u>				22b. DATE SIGNED <u>Feb 21 1961</u>			
22c. PHYSICIAN'S NAME (Type) <u>BERNARD A. FITZGERALD</u>				22d. ADDRESS <u>217 UNIV. BLVD E, S.S. MD 2-21-61</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>FEB 24 61</u>			
23c. NAME OF CEMETERY OR CREMATORY <u>CALVARY CEMETERY</u>				23d. LOCATION (City, town, or county) (State) <u>EVANSTON ILL</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>DeVol Funeral Home</u>				25a. REC'D BY REGISTRAR <u>Washington W.C.</u>			
25b. REGISTRAR'S SIGNATURE <u>Cashner &amp; Thayer</u>				DATE <u>FEB 27 61</u>			





Page 4  
TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
2056  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda, (Rural)</b> c. LENGTH OF STAY IN 1b <b>69 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Fredricksburg</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>804 Adams</b> d. STREET ADDRESS <b>804 Adams</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Jack</b> First Middle Last <b>CLIFFORD</b>		4. DATE OF DEATH Month Day Year <b>February 12 1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-13-1887</b>
9. AGE (In years lost birthday) <b>73</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mariner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Navy</b>	
11. BIRTHPLACE (State or foreign country) <b>New Mexico</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John CLIFFORD</b>		14. MOTHER'S MAIDEN NAME <b>Clara Belle EASLY</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WWI &amp; II</b>		16. SOCIAL SECURITY NO. <b>(W) Mrs. Maude F. Clifford, same as #2 above</b>	
17. INFORMANT <b>(W) Mrs. Maude F. Clifford, same as #2 above</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>leukemia</b> 600.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Chronic pyelonephritis</b> DUE TO (c) <b>14 year</b> INTERVAL BETWEEN ONSET AND DEATH <b>14 year</b>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from <b>Dec. 5 1960</b> to <b>Feb. 12 1961</b> , that (X) (we) last saw the deceased alive on <b>Feb. 12 1961</b> , and that death occurred at <b>5A</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>William P. Baker</b> M.D.		22b. DATE SIGNED <b>2-12-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>William P. Baker, LT, MC, USN</b>		22d. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-Transit 2-13-61</b>		23b. DATE THEREOF <b>2-13-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Oak Hill Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Fredericksburg Virginia</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>R. A. Humphrey</b> Address <b>General Home, Bethesda, Md.</b>		25a. REC'D BY REGISTRAR <b>FEB 14 '61</b> DATE	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>			

CERTIFICATE OF DEATH

2858

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## 02034

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Kentucky</b> b. COUNTY <b>Whitesburg</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>49 Days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The clinical Center, Bethesda 14, Md.</b>		d. STREET ADDRESS <b>Box 391</b>	
3. NAME OF DECEASED (Type or print) <b>Chester</b> <b>(None)</b> <b>Combs</b>		4. DATE OF DEATH <b>February</b> <b>17</b> <b>19 61</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 9, 1926</b>
9. AGE (In years last birthday) <b>34</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Coal Miner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Mining</b>	11. BIRTHPLACE (State or foreign country) <b>Kentucky</b>
13. FATHER'S NAME <b>William Combs</b>		14. MOTHER'S MAIDEN NAME <b>Sallie Banks</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. <b>WW II</b> <b>403-22-5791</b>	
17. INFORMANT <b>The Medical Records</b>		Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypoglycemia</b> <b>204.3</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Massive infiltration of pancreas by leukemia</b> DUE TO (c) <b>Acute lymphocytic leukemia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 Days</b> <b>1 Year</b> <b>1 Year</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>December 30, 1960</b> to <b>February 17, 1961</b> , that (I) (we) last saw the deceased alive on <b>February 17, 1961</b> , and that death occurred at <b>5:50 PM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>R. E. Rieselbach</b>		22b. DATE SIGNED <b>2/18/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>R. E. Rieselbach M.D.</b>		22d. ADDRESS <b>The Clinical Center National Institutes of Health Bethesda 14, Maryland</b>	
23a. DATE OF CREMATION <b>removal</b>		23b. DATE THEREOF <b>2/18/61</b>	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State) <b>Whitesburg, Kentucky</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>St. Hines Co</b>		25a. REC'D BY REGISTRAR <b>2901 14th NW</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Evans</b>		DATE <b>FEB 20 '61</b>	

CERTIFICATE OF DEATH

2057

Name of Deceased		Sex		Age		Date of Birth		Place of Birth	
John Doe		Male		45		Jan 1, 1910		Boston, Mass.	
Cause of Death		Manner of Death		Occupation		Residence		Date of Death	
Heart Disease		Natural		Teacher		123 Main St.		Jan 15, 1955	
Physician		Hospital		Funeral Home		Burial Place		Date of Burial	
Dr. J. Smith		St. Mary's		Doe & Sons		Catholic Cemetery		Jan 18, 1955	
Signature of Registrar		Signature of Physician		Signature of Funeral Home		Signature of Burial Place		Signature of Deceased	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any death is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

VS. A15ME  
5M 7/59

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## 2058 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02035

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b> c. LENGTH OF STAY IN 1b <b>D.O.A.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Washington Saint Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville (Chillum) 16-2-2</b> d. STREET ADDRESS <b>805 Sheridan St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Louis Antonio Commiso</b>		4. DATE OF DEATH <b>2 1 19 61</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-25-10</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Guard Fed Beau Engraving and Printing</b>		11. BIRTHPLACE (State or foreign country) <b>Trenton New Jersey</b>	
13. FATHER'S NAME <b>Domenic Commiso</b>		14. MOTHER'S MAIDEN NAME <b>Mary Feronni</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>?</b>	
17. INFORMANT <b>Mrs Josephine Commiso</b>		Address <b>805 Sheridan Hyattsville</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarct (left)</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary occlusion</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Frank J. Broschert</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>FRANK J. Broschert</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>2/4/61</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>		22d. LOCATION (City, town, or country) (State) <b>Prince Georges, Md.</b>	
23. FUNERAL DIRECTOR <b>A. Hines Co</b>		ADDRESS <b>2901 14th NW</b>	
24a. REC'D BY REGISTRAR <b>FEB 2 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	





## CERTIFICATE OF DEATH

02036

1. PLACE OF DEATH o. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE		MARYLAND		b. COUNTY		MONTGOMERY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS											
3. NAME OF DECEASED (Type or print)		First		Middle		Last		4. DATE OF DEATH		Month		Day		Year	
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years less birthday) yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?									
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME													
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Obesity		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)					
21. I certify that (I) (this hospital) attended the deceased from _____, 1960, to Feb 4, 1961, that (I) (we) last saw the deceased alive on Feb 3, 1961, and that death occurred at 4:30 PM, from the causes and on the date stated above.															
22a. SIGNATURE R. A. Yates, M. D.		22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) R. A. YATES, M. D.		22d. ADDRESS OLNEY, MARYLAND									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county)		(State)							
24. FUNERAL DIRECTOR'S SIGNATURE Robert L. Sumner		ADDRESS Rockville, Md.		25a. REC'D BY REGISTRAR DATE FEB 14 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Kraus									

5052

CERTIFICATE OF DEATH

MONTGOMERY

MONTGOMERY

OLNEY

12 DAYS

2 LUNG SPINE

MONTGOMERY GENERAL HOSPITAL

5711 BOWDOIN ROAD

BRANDET

GOOD

FEBRUARY 8

FEMALE COLORADO

12-12-1983

HOUSTON

MARYLAND

BARKER DEWITT

LARNA HOWELL

OLNEY, MARYLAND

HOSPITAL RECORDS

CHIEF CLERK

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

2060

02037

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>241 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>U. S. Naval Hospital</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b> d. STREET ADDRESS <b>1611 Farragut Ave.</b> a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Louise Ellis COOK</b>		4. DATE OF DEATH <b>February 25 19 61</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-3-96</b>
9. AGE (In years last birthday) <b>64 yrs.</b>		10. IF UNDER 1 YEAR Months <b>64</b> Days <b>19</b> Hours <b>61</b> Min.	
11. BIRTHPLACE (County & State, or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Robert ELLIS</b>		14. MOTHER'S MAIDEN NAME <b>Mary REYNOLDS</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>207-05-9574</b>	
17. INFORMANT <b>(S) Irving R. Cook, same as #2 above</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Leukemia</b> DUE TO cause last. (c) <b>Advanced generalized lymphosarcoma</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>June 29 1960</b> to <b>Feb. 25 1961</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Feb. 25 1961</b> , and that death occurred at <b>2:18 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>F. H. O'Connell</b>		22b. DATE SIGNED <b>2-26-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>F. H. O'CONNELL, LCDR, MC, USN</b>		22d. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3-1-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Park Lawn Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Rockville Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Tyson Wheeler</b> Tyson Wheeler Funeral Home, Rockville, Md.		25a. REC'D BY REGISTRAR DATE <b>FEB 28 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>			

14

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TO HOSPITAL OR FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Pages may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

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M

2061

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02038

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda, Maryland</u>	
c. LENGTH OF STAY IN 1b <u>-</u>		d. STREET ADDRESS <u>6600 Bradley Blvd</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>6600 Bradley Blvd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Brunhilde O. Cross</u>		4. DATE OF DEATH <u>Feb. 18 1961</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 23, 1903</u>
9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Grand Valley, Kansas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Stephen Oakleaf</u>		14. MOTHER'S MAIDEN NAME <u>Gladys Wallace</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mr. John W. Cross</u>		Address <u>6600 Bradley Blvd.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <u>Myocardial Failure</u> 410X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>Mitral Insufficiency &amp; Triangular Rheumatic Heart Disease</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Aug. 27/0</u> 19 <u>53</u> to <u>2/18</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>2/10</u> 19 <u>61</u> , and that death occurred at <u>8:45</u> P.M. from the causes and on the date stated above.		22a. SIGNATURE <u>William L. Howell</u> M.D.	
22b. DATE SIGNED <u>2/18/61</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <u>William L. Howell</u>		22d. ADDRESS <u>5401 Western Ave NW</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/22/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Prince George Co. Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>	
25a. REC'D BY REGISTRAR <u>FEB 21 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

1901

1000 Bushy Bay  
to the  
H. H. H.

Apple Valley  
to the

Jan 23 1901  
Apple Valley  
to the

Robert A. Farnham, Bethesda, Maryland  
2/22/01  
L. Lincoln Cemetery, Prince George Co. Md.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 7/59

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>10 min.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Suburban</b>										2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b> d. STREET ADDRESS <b>4713 DeRussey Pkwy.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																													
3. NAME OF DECEASED (Type or print) <b>Nora</b>					First <b>Etta</b>					Middle <b>Crox</b>					Last <b>Feb. 23</b>					4. DATE OF DEATH Month <b>19</b> Day <b>61</b> Year <b>61</b>																			
5. SEX <b>F</b>					6. COLOR OR RACE <b>White</b>					7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH <b>Dec. 25, 1888</b>					9. AGE (In years last birthday) <b>72</b> yrs.					IF UNDER 1 YEAR Months <b>72</b> Days <b>72</b> Hours <b>72</b> Min. <b>72</b>					IF UNDER 24 HRS. Hours <b>72</b> Min. <b>72</b>									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>School teacher</b>										10b. KIND OF BUSINESS OR INDUSTRY <b>Gov't.</b>										11. BIRTHPLACE (State or foreign country) <b>Tenn.</b>										12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>									
13. FATHER'S NAME <b>William Harrison Shultz</b>										14. MOTHER'S MAIDEN NAME <b>Trotter</b>																													
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>										16. SOCIAL SECURITY NO. <b>408-01-3272A</b>										17. INFORMANT <b>Walter C. Clark, son-in-law</b>										Address <b>same address</b>									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Irreversible Shock</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>570.2</b> (b) <b>Infarction of Sigmoid Colon</b> DUE TO (c) <b>Strangulation by adhesive band</b>										INTERVAL BETWEEN ONSET AND DEATH <b>hours</b> <b>1 day</b> <b>1 day</b>																													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																													
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																													
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>										20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>										20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)										20f. (City or town) (County) (State)									
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										CHIEF MEDICAL EXAMINER <b>Frank J. Broschant</b> M.D. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <b>2-24-61</b>										DATE SIGNED <b>2-24-61</b>																			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Bur-Transit</b>										22b. DATE THEREOF <b>2/25/61</b>										22c. NAME OF CEMETERY OR CREMATORY <b>Benton Cemetery</b>										22d. LOCATION (City, town, or country) (State) <b>Benton, Tennessee</b>									
23. FUNERAL DIRECTOR <b>Robert A. Pumphrey</b>										ADDRESS <b>Bethesda, Maryland</b>										24a. REC'D BY REGISTRAR <b>FEB 28 '61</b>										24b. REGISTRAR'S SIGNATURE <b>Anthony L. House</b>									



Robert A. Humphrey, Bethesda, Maryland  
 3/25/61  
 Newton Cemetery, Newton, Tennessee

Transmittal by adhesive band  
 Information of State Police  
 Investigation of State Police

Letter of Mr. J. Edgar Hoover  
 Director, Federal Bureau of Investigation  
 Washington, D.C.

Robert A. Humphrey  
 Bethesda, Maryland  
 3/25/61

Newton Cemetery  
 Newton, Tennessee  
 3/25/61

Newton Cemetery  
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 3/25/61

Newton Cemetery  
 Newton, Tennessee  
 3/25/61



5068

CERTIFICATE OF DEATH

DATE OF DEATH

TIME

PLACE

NAME OF DECEASED

AGE

SEX

CAUSE OF DEATH

DATE

TIME

NAME OF DECEASED

AGE

SEX

DATE

TIME

PLACE

NAME OF DECEASED

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any other person is needed, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MDARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**2064 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

1. PLACE OF DEATH e. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Md</u> b. COUNTY <u>Montg</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. LENGTH OF STAY IN 1b <u>25 yrs</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>09 Rockville</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>15 1/2 Fayette st</u>				d. STREET ADDRESS <u>1 15 1/2 Fayette st</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Fred Turner Cunningham</u>				4. DATE OF DEATH Month <u>Feb</u> Day <u>21</u> Year <u>1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-28-81</u>	
9. AGE (In years last birthday) <u>79</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ind.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
13. FATHER'S NAME <u>Geo. Cunningham</u>				14. MOTHER'S MAIDEN NAME <u>Turner</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service)				16. SOCIAL SECURITY NO. <u>216-30-4856</u>			
17. INFORMANT <u>Edna Cunningham (wife)</u>				Address <u>Stm 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschart</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>2-21-61</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>2/24/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln</u>		22d. LOCATION (City, town, or country) (State) <u>Prince George County, Md.</u>	
23. FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home</u> <u>1331 E. Montgomery Avenue, Rockville, Md.</u>				24a. REC'D BY REGISTRAR <u>FEB 24 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MEDICAL CERTIFICATION





1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any death is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2065 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02042

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			c. LENGTH OF STAY IN 1b <u>1 hr</u>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hosp</u>			e. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>15 Silver Spring</u>		
f. STREET ADDRESS <u>13914 Mills Ave</u>			a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>Charles I Curtis</u>			4. DATE OF DEATH <u>Feb 4 1961</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-1-24</u>	9. AGE (in years last birthday) <u>36</u> yrs.	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dog Breeder</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Kennel Owner</u>		
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>			12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		
13. FATHER'S NAME <u>WM. IRVIN CURTIS</u>			14. MOTHER'S MAIDEN NAME <u>Viola May Chapman</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes WW II</u>			16. SOCIAL SECURITY NO. <u>NO</u>		
17. INFORMANT <u>Police record</u>			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage + laceration</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>976X</u> DUE TO (c)					
INTERVAL BETWEEN ONSET AND DEATH <u>1 hr. 20 min</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Self-inflicted bullet wound Thru skull</u>		
20c. TIME OF INJURY Month, Day, Year <u>7:32 p.m. 2-4 1961</u>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Auto</u>			20f. (City or town) <u>Bethesda</u> (County) <u>Montg</u> (State) <u>md</u>		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Broschart</u>			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
			Address (Street, city, town, or county) <u>2-4-61</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/7/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's</u>	
				22d. LOCATION (City, town, or country) (State) <u>Rockville, Md.</u>	
23. FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home</u>			ADDRESS <u>1331 E. Montgomery Avenue Rockville, Md.</u>		
24a. REC'D BY REGISTRAR <u>FEB 9 '61</u>			24b. REGISTRAR'S SIGNATURE <u>Arthur S. Haines</u>		

MEDICAL CERTIFICATION

IN EIGHT  
THIRTY

8002



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, it should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. The pages, and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

2066 MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
2066 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 02043

1. PLACE OF DEATH e. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>D.O.A.</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Gaithersburg</b>		d. STREET ADDRESS <b>Rt. 3</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Suburban Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Edna</b>		First <b>Edna</b> Middle <b>Lenora</b> Last <b>Davidson</b>		4. DATE OF DEATH Month <b>February</b> Day <b>4</b> Year <b>19 61</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 3, 1919</b>	9. AGE (In years last birthday) <b>41</b> yrs.	IF UNDER 1 YEAR Months <b>41</b> Days <b>41</b>	IF UNDER 24 HRS. Hours <b>41</b> Min. <b>41</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Robert Hogsdon</b>				14. MOTHER'S MAIDEN NAME <b>Ethel Eastridge</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>—</b>		16. SOCIAL SECURITY NO. <b>—</b>		17. INFORMANT (Husband) <b>George Davidson</b>		Address <b>As above</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> <b>Cornary occlusion</b> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>1 hr.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Frank J. Brusehart</b>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>2-4-61</b>	
EXAMINER'S NAME (Type) <b>FRANK J. BRUSEHART</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2-6-61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Forest Oak</b>		22d. LOCATION (City, town, or country) (State) <b>Gaithersburg. Md.</b>	
23. FUNERAL DIRECTOR <b>Arthur S. Kraus</b>				ADDRESS <b>316 E. Diamond Gaithersburg Md</b>		24a. REC'D BY REGISTRAR <b>FEB 7 '61</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

1000

1000

Montgomery

Settled

Shannon Hospital

John

Female

Monmouth

Robert Gordon

Robert Gordon

(Maiden)

George Davidson

As above

Davidson

October 3, 1919

At

U.S.A.

Davidson

John

February 4, 1920

Calicut

Montgomery

Montgomery

## 02044

Arthur L. Kraus

VR A15 (4)  
15M 9/60



2007

Monogram

Seashells

3 days

Washington

Eastern Hospital

2500 Noorank Avenue, N. W.

Herbert

Davis

February 1

Male

White

6/7/58

72

Gen. Vice Pres.

Gen. Secretary

Washington, D. C.

William W. Davis

Virginia Shop

Austin Davis (son) 4408 Roschell Drive  
Bethesda, Md.

Member of the Board of Directors

Executive Committee

2/7

2/7

2/7/58

George Shatt

1001 2nd Ave. N. W. Washington, D. C.

2-20-61

Bethesda, Md.

Rockville, Md.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in. The funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2068

## CERTIFICATE OF DEATH

02045

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <i>md</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>residence</i>		d. STREET ADDRESS <i>17 Oswego Ave</i>	
3. NAME OF DECEASED (Type or print) First <i>James</i> Middle <i>Richard</i> Last <i>Dawes</i>		4. DATE OF DEATH Month <i>February</i> Day <i>20</i> Year <i>1961</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>W.C.</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>January 9 1875</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Cement Finisher</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Landscaping</i>	9. AGE (In years last birthday) <i>86</i> yrs. IF UNDER 1 YEAR: Months <i>86</i> Days <i>86</i> Hours <i>86</i> Min. <i>86</i>
11. BIRTHPLACE (State or foreign country) <i>Culpepper, VIRGINIA</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Howard Dawes</i>		14. MOTHER'S MAIDEN NAME <i>Winnie Ferguson</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>215-14-7426</i>	
17. INFORMANT <i>Winnie Ferguson</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Internal Hemorrhage Gastric</i> <i>151X</i> DUE TO <i>Anemia Nephrosis</i> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO <i>Gastric Carcinoma</i> (b) <i>gastric Carcinoma</i> (c) <i>gastric Carcinoma</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <i>a. m.</i> <i>19</i> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>July 10, 1960</i> to <i>Feb 20, 1961</i> , that I last saw the deceased alive on <i>Feb 19, 1961</i> , and that death occurred at <i>9:55 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Hebert Sewell</i> M.D.		ADDRESS (Street, city or town, state) <i>NORBECK</i> DATE SIGNED <i>2:20:61</i>	
PHYSICIAN'S NAME (Type) <i>WEBSTER SEWELL</i>		<i>SILVER SPRING MD.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	22b. DATE THEREOF <i>2.25.61</i>	22c. NAME OF CEMETERY OR CREMATORY <i>LINCOLN MEM. CEM.</i>	22d. LOCATION (City, town, or county) (State) <i>SUITLAND, MARYLAND</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert L. McQuinn</i> ADDRESS <i>1820 9TH ST., N.W.</i>		24a. REC'D BY REGISTRAR <i>DATE FEB 24 '61</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>

WASHINGTON, D.C.

NEW YORK STATE DEPARTMENT OF HEALTH-ALBANY 18

Page 4 of 4  
TO HOSPITAL ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

2069

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

02046

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN lb <b>10 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Marys</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>California</b> d. STREET ADDRESS <b>Box #5</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First <b>Martin</b> Middle <b>Valentine</b> Last <b>DICKMANN</b>			4. DATE OF DEATH Month <b>February</b> Day <b>16</b> Year <b>19 61</b>												
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Caucasian</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1-13-14</b>		9. AGE (In years lost birthday) <b>47</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mariner</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Navy</b>				11. BIRTHPLACE (State or foreign country) <b>New York</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Martin DICKMANN</b>						14. MOTHER'S MAIDEN NAME <b>Bertha FOLKNER</b>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>				16. SOCIAL SECURITY NO. <b>1936 to 1960 081-32-5500</b>		17. INFORMANT <b>(W) Mrs. Anna N. Dickmann, same as #2 above</b>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cirrhosis, liver, Laennec's</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) (c)												INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Feb. 6 1961 12:09PM Feb. 16 1961</b>		(County) <b>Virginia</b>		(State)			
21. I certify that <b>NO</b> (this hospital) attended the deceased from <b>Feb. 6 1961 12:09PM</b> to <b>Feb. 16 1961</b> , that <b>he</b> (we) last saw the deceased alive on <b>Feb. 16 1961</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.															
22a. SIGNATURE <b>Paul G. Linaweaver, Jr.</b>						M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>2-16-61</b>							
22c. PHYSICIAN'S NAME (Type) <b>Paul G. LINAWEAVER, JR., LT, MC, USN</b>						22d. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>2-21-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>				23d. LOCATION (City, town, or county) (State) <b>Arlington Virginia</b>					
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robinson Funeral Home, Leonardtown, Md.</b>						25a. REC'D BY REGISTRAR <b>FEB 24 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>							

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2002

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Page 4  
TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
2070  
CERTIFICATE OF DEATH  
02047

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park,</b> c. LENGTH OF STAY IN 1b <b>28</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington Sanitarium &amp; Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring,</b> d. STREET ADDRESS <b>1917 Seminary Road,</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Digman</b>		4. DATE OF DEATH Month Day Year <b>February 21, 1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 21, 1961</b>
9. AGE (In years last birthday) <b>1</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. <b>1 18</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>America</b>	
13. FATHER'S NAME <b>NOT GIVEN</b>		14. MOTHER'S MAIDEN NAME <b>Jean Berneda Digman</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>	
17. INFORMANT <b>mother</b>		Address <b>same as above</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>762.5 Anoxia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Immaturity (5 mos)</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19, and that death occurred at M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Wallace H. McCune,</b> M.D.		22b. DATE <b>24 Feb 61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Wallace N. McCune, M. D.</b>		22d. ADDRESS <b>911 Silver Spring Avenue, Silver Spring, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE THEREOF <b>2-23-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Washington Sanitarium &amp; Hospital</b>		23d. LOCATION (City, town, or county) (State) <b>Takoma Park, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Hare, M. D.</b>		25a. REC'D BY REGISTRAR <b>FEB 27 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hare</b>			

2075 261XV0

CERTIFICATE OF DEATH

5070

Name of Deceased		Date of Birth	
Sex		Race	
Place of Birth		Date of Death	
Cause of Death		Place of Death	
Signature of Physician		Signature of Registrar	
Date of Certificate		Place of Issuance	



TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 only P should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2071

## CERTIFICATE OF DEATH

02048

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>3 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>U. S. Naval Hospital</b>			<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Norfolk</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>1018 Rockbridge Ave. - Apt. 162C</b> d. STREET ADDRESS <b>1018 Rockbridge Ave. - Apt. 162C</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
<b>3. NAME OF DECEASED</b> (Type or print) <b>Peri Jeanette DILLARD</b>			<b>4. DATE OF DEATH</b> Month Day Year <b>February 26 19 61</b>		
<b>5. SEX</b> <b>Female</b>			<b>6. COLOR OR RACE</b> <b>Caucasian</b>		
<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>			<b>8. DATE OF BIRTH</b> <b>1-31-61</b>		
<b>9. AGE</b> (In years last birthday) yrs. Months Days <b>27</b>			<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>10a. USUAL OCCUPATION</b> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Virginia</b> <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>		
<b>13. FATHER'S NAME</b> <b>John Samuel DILLARD</b>			<b>14. MOTHER'S MAIDEN NAME</b> <b>Dorise Jeanette TRAVIS</b>		
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>			<b>16. SOCIAL SECURITY NO.</b> <b>None</b>		
<b>17. INFORMANT</b> <b>(F) J. S. Dillard, same as #2 above</b>			<b>Address</b>		
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CONGENITAL HEART DISEASE, (TRICUSPID ATRESIA, 7.54.0</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ATRIAL SEPTAL DEFECT, VENTRICULAR SEPTAL 3wks.</b> (c) <b>DEFECT</b>					
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b> <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State) <b>21. I certify that</b> <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Feb. 23 19 61</b> to <b>Feb. 26 19 61</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Feb. 26 19 61</b> , and that death occurred at <b>2:15PM</b> , from the causes and on the date stated above.					
<b>22a. SIGNATURE</b> <b>J. E. MC CLENATHAN</b> <b>22c. PHYSICIAN'S NAME</b> (Type) <b>J. E. MC CLENATHAN, CDR, MC, USN</b> <b>22b. DATE THEREOF</b> <b>2-28-61</b> <b>22d. ADDRESS</b> <b>U. S. Naval Hospital, Bethesda, Md.</b> <b>22e. ATTENDING PHYS.</b> <input type="checkbox"/> <b>22f. MED. DIRECTOR</b> <input type="checkbox"/> <b>22g. STAFF PHYS.</b> <input checked="" type="checkbox"/> <b>22h. DATE SIGNED</b> <b>2-27-61</b>					
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b> <b>23b. DATE THEREOF</b> <b>2-28-61</b> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Arlington National</b> <b>23d. LOCATION</b> (City, town or county) (State) <b>Arlington Virginia</b>					
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Tyson Wheeler</b> <b>24a. ADDRESS</b> <b>Tyson Wheeler Funeral Home, Rockville, Md.</b> <b>24b. REC'D BY REGISTRAR</b> <b>DATE FEB 28 '61</b> <b>24c. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Hines</b>					

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**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

02049

2072

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Henrico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Richmond</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				d. STREET ADDRESS <b>205 South Mulberry Street</b>			
3. NAME OF DECEASED (Type or print) First <b>Theodora</b> Middle <b>Olive</b> Last <b>Downing</b>				4. DATE OF DEATH Month <b>February</b> Day <b>15</b> Year <b>1961</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 5, 1908</b>		9. AGE (In years last birthday) <b>53</b> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Banking</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Maurice Downing</b>				14. MOTHER'S MAIDEN NAME <b>Daisy Redgrove</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>226-07-6840</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Congestion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma, Right Breast</b> DUE TO (c) <b>Carcinoma, Ovary</b>							INTERVAL BETWEEN ONSET AND DEATH <b>10 Years</b> <b>5 Years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hemopericardium</b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>February 14, 1961</b> to <b>February 15, 1961</b> , that (I) (we) last saw the deceased alive on <b>February 15, 1961</b> , and that death occurred at <b>1:10 a.m.</b> , from the causes and on the date stated above.							
22a. SIGNATURE <i>Martin Nydick</i>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>2/15/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>MARTIN NYDICK, M.D.</b>				22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/17/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Blandford Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Petersburg, Virginia</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>				ADDRESS <b>Bethesda, Maryland</b>		25a. REC'D BY REGISTRAR <b>FEB 17 1961</b>	
				25b. REGISTRAR'S SIGNATURE <i>Arthur S. Brand</i>			

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2073

## CERTIFICATE OF DEATH

02050

1. PLACE OF DEATH COUNTY <b>Montgomery</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>47 Bethesda</b> d. STREET ADDRESS <b>8101 Custer Rd.</b> a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Fairland</b>			c. LENGTH OF STAY IN 1b		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Fairland Nursing Home</b>					
3. NAME OF DECEASED (Type or print) First Middle Last <b>CARL AUGUST DUEHRING</b>			4. DATE OF DEATH Month Day Year <b>Feb. 1 19 61</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4 May 1880</b>	9. AGE (In years last birthday) yrs. <b>80</b>	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret'd. Merchant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Hardware</b>		11. BIRTHPLACE (County & State, or foreign country) <b>D.C.</b>	
12. CITIZEN OF WHAT COUNTRY <b>USA</b>					
13. FATHER'S NAME <b>August Duehring</b>			14. MOTHER'S MAIDEN NAME <b>Unknown</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. 17. INFORMANT Address <b>Mrs. C.B. Gilpin Same as # 2</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b> DUE TO (b) <b>Arteriosclerotic heart disease</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (c) <b>Generalized arteriosclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>years</b> <b>years</b>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work et work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>Dec. 22</b> , 19 <b>57</b> , to <b>Feb. 1</b> , 19 <b>61</b> , that (I) ( <del>was</del> ) last saw the deceased alive on <b>Tan 29</b> , 19 <b>61</b> , and that death occurred at <b>2 A.M.</b> , from the causes and on the date stated above.					
22a. SIGNATURE <b>Aaron H. Traum</b> M.D.			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>Feb. 1 1961</b>
22c. PHYSICIAN'S NAME (Type) <b>Aaron H. Traum, M. D.</b>			22d. ADDRESS <b>8237 Georgia Ave Silver Spring Md.</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE THEREOF <b>4 Feb. 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lee's Crematorium</b>	
23d. LOCATION (City, town or county) (State) <b>Washington, D.C.</b>					
24. FUNERAL DIRECTOR'S SIGNATURE <b>Lee Funeral Home 300-4th St. N.E. Wash. D.C.</b>			25a. REC'D BY REGISTRAR <b>FEB 2 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Traum</b>

2073

CHURCH OF DEATH

10/10/11

Postmaster

ad.

Barbados

Barbados

Left in morning home

8101 Green Rd.

CHURCH

AUGUST

CANAL

10 - 01

White 1880 30

USA

U.S.

Barbados

Ref'd. Mchans

Unknown

August Mchans

1

Mr. G.B. Quinn

no

Green Rd. 8101

Postmaster 100-401



Page 4  
TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
2074  
CERTIFICATE OF DEATH  
02051

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Mont.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN lb <u>15 hrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>507 Bethesda</u>	
3. NAME OF DECEASED (Type or print) <u>Casco</u> First <u>G.</u> Middle <u>H.</u> Last <u>Duke</u>		4. DATE OF DEATH <u>Feb.</u> Month <u>6</u> Day <u>1961</u> Year	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/15/93</u>
9. AGE (In years last birthday) <u>67</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Manager</u>		12. KIND OF BUSINESS OR INDUSTRY <u>Used Car Lot</u>	
13. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		14. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
15. FATHER'S NAME <u>Casco Lee Duke</u>		16. MOTHER'S MAIDEN NAME <u>Charal Godsey</u>	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		18. SOCIAL SECURITY NO. <u>577-10-8731</u>	
19. INFORMANT <u>Louise I. Duke</u>		20. ADDRESS <u>same as above</u>	
21. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Acute Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>15 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>2-6</u> <u>1961</u> , to <u>2-6</u> <u>1961</u> , that (I) ( <u>we</u> ) last saw the deceased alive on <u>2-6</u> <u>1961</u> , and that death occurred at <u>5 P.M.</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>P. P. Andrews</u>		22b. DATE SIGNED <u>2/6/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>P. P. ANDREWS M.D.</u>		22d. ADDRESS <u>4201 FESSENDEN ST. N.W. WASH. D.C.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/9/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		25a. REC'D BY REGISTRAR <u>Arthur S. Kraus</u>	
25b. REGISTRAR'S SIGNATURE <u>Robert A. Pumphrey</u>		25c. DATE <u>FEB 9 '61</u>	



Page 4  
TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

2075  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

02052

1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FAIRFAX</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LAUREL</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>FAIRFAX NURSING HOME</u>		d. STREET ADDRESS <u>479-MAIN ST</u>	
3. NAME OF DECEASED (Type or print) First <u>CLAUDIA</u> Middle <u>EDMONSTON</u> Last <u>EDMONSTON</u>		4. DATE OF DEATH Month <u>Feb-</u> Day <u>21</u> Year <u>1961</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W-</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 20, 1877</u>
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CLERK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>GOVERNMENT</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John P. Edmonston</u>		14. MOTHER'S MAIDEN NAME <u>FRANCES WHITWORTH</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>(If yes, give war or dates of service)</u>	
17. INFORMANT <u>(Address)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> 331X DUE TO <u>Generalized arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) <u></u> (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>March 14, 1960</u> to <u>Feb-21, 1961</u> that (I) (we) last saw the deceased alive on <u>Feb-20, 1961</u> , and that death occurred at <u>4:15</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Boris Rabkin</u>		22b. DATE SIGNED <u>Feb-21, 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>BORIS RABKIN, M.D.</u>		22d. ADDRESS <u>1818 University Boulevard East, Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/23/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St Philip Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Laurel, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>DeWitt Donaldson Laurel Md.</u>		25a. REC'D BY REGISTRAR <u>DATE FEB 27 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

1907

1. Name of deceased: \_\_\_\_\_

2. Sex: \_\_\_\_\_

3. Age: \_\_\_\_\_

4. Date of birth: \_\_\_\_\_

5. Place of birth: \_\_\_\_\_

6. Date of death: \_\_\_\_\_

7. Time of death: \_\_\_\_\_

8. Cause of death: \_\_\_\_\_

9. Place of death: \_\_\_\_\_

10. Signature of attending physician: \_\_\_\_\_

11. Signature of registrar: \_\_\_\_\_

12. Date of registration: \_\_\_\_\_

Page 4  
TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.  
TO ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
2076  
CERTIFICATE OF DEATH  
02053

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Arlington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>24 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center</b>		e. STREET ADDRESS <b>204 South Ivy Street</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Anderson</b> Last <b>Ellis</b>		4. DATE OF DEATH Month <b>February</b> Day <b>20,</b> Year <b>19 61</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 21, 1900</b>
9. AGE (In years last birthday) <b>61</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Samuel Ellis</b>		14. MOTHER'S MAIDEN NAME <b>Corrie Perkins</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>579-01-4186</b>	
17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple Pulmonary Embolism - Myocardial Infarction</b> DUE TO <b>2 days</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Atherosclerosis of Hypertensive Cardiovascular Disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Medulla Cerebralis Artery Thrombosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>January 27, 19 61</b> to <b>February 20, 19 61</b> , that (I) (we) last saw the deceased alive on <b>Feb. 20, 19 61</b> and that death occurred at <b>8:12 AM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Thomas C. Merigan</b>		22b. DATE SIGNED <b>2-20-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Thomas C. Merigan M.D.</b>		22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2-22-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest</b>		23d. LOCATION (City, town, or county) (State) <b>Louisiana La.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>IVES FUNERAL HOME, INC. (P.D.)</b>		25a. REC'D BY REGISTRAR <b>DATE FEB 23 '61</b>	
ADDRESS <b>Arlington, Va.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

5075

CERTIFICATE OF DEATH

Montgomery, Virginia, Arlington

Age: 30 days

The Clinical Center

William, Johnson, 2115, February 20, 61

Birth: 21, 1930, of

Unknown, Virginia, 104

242-II-0-0-0 The Clinical Center, Bethesda II, Maryland  
The Medical Record  
Cornea Position

January 27, 1961

Feb. 20, 61

The Clinical Center, National  
Institute of Health, Bethesda II, Maryland

February 20, 1961

6-22-61



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2077

CERTIFICATE OF DEATH

Reg. Dist. No.

02054

1. PLACE OF DEATH o. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Prince George's</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>	c. LENGTH OF STAY IN 1b <i>4 weeks</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>West Hyattsville</i> <i>1656-2</i>	
d. NAME OF HOSPITAL (If in hospital, give street address) OR INSTITUTION <i>Harvest Nursing Home</i>		d. STREET ADDRESS <i>8230 14th Avenue</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <i>ELIZABETH</i> First Middle Last		4. DATE OF DEATH <i>February</i> Month Day Year <i>1</i> <i>1961</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>Cauc.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>1/10/1862</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired --- Dress</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Maker</i>	11. BIRTHPLACE (State or foreign country) <i>Virginia</i>
13. FATHER'S NAME <i>James Entwistle</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>none</i>	17. INFORMANT <i>J. Douglas Pickens-1519 Live Oak Drive Silver Spring, Maryland</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.0 Congestive heart failure</i> DUE TO (b) <i>Arteriosclerotic heart disease</i> DUE TO (c) <i>Generalized arteriosclerosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Malnutrition</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>12/28</i> , 19 <i>60</i> , to <i>2/1</i> , 19 <i>61</i> , that I last saw the deceased alive on <i>1/31</i> , 19 <i>61</i> , and that death occurred at <i>11:35 a.m.</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>918 University Blvd. E Silver Spring, Md.</i> DATE SIGNED <i>2/1/61</i> ACTUAL SIGNATURE <i>Eino Magi</i> M.D. PHYSICIAN'S NAME (Type) <i>EINO MAGI</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>2/4/61</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Ivy Hill Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Alexandria, Virginia</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>The HH Hines Co 2901-1428th</i>		24a. REC'D BY REGISTRAR DATE <i>FEB 3 '61</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. H.</i>

CERTIFICATE OF DEATH

5073

DECEASED'S NAME [Illegible]		SEX [Illegible]		AGE [Illegible]	
DATE OF BIRTH [Illegible]		PLACE OF BIRTH [Illegible]		MARRIAGE [Illegible]	
DATE OF DEATH [Illegible]		PLACE OF DEATH [Illegible]		CAUSE OF DEATH [Illegible]	
TIME OF DEATH [Illegible]		MEDICAL HISTORY [Illegible]		PRESENT ILLNESS [Illegible]	
SIGNATURE OF PHYSICIAN [Illegible]		SIGNATURE OF DEATH REGISTRAR [Illegible]		SIGNATURE OF WITNESS [Illegible]	
ADDRESS OF DECEASED [Illegible]		ADDRESS OF DEATH REGISTRAR [Illegible]		ADDRESS OF WITNESS [Illegible]	
CITY [Illegible]		COUNTY [Illegible]		STATE [Illegible]	
ZIP CODE [Illegible]		TELEPHONE [Illegible]		FAX [Illegible]	
SIGNATURE OF DEATH REGISTRAR [Illegible]		SIGNATURE OF WITNESS [Illegible]		SIGNATURE OF PHYSICIAN [Illegible]	
ADDRESS OF DEATH REGISTRAR [Illegible]		ADDRESS OF WITNESS [Illegible]		ADDRESS OF PHYSICIAN [Illegible]	
CITY [Illegible]		COUNTY [Illegible]		STATE [Illegible]	
ZIP CODE [Illegible]		TELEPHONE [Illegible]		FAX [Illegible]	

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

2078

020557

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY in 1b <u>8 hrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium &amp; Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> <span style="float: right;">b. COUNTY <u>PRINCE GEORGES</u></span> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> d. STREET ADDRESS <u>6518 Flander Drive</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
<b>3. NAME OF DECEASED</b> (Type or print) <u>Herman Nourse Esworthy</u> First Middle Last				<b>4. DATE OF DEATH</b> <u>February 10 1961</u> Month Day Year									
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>Cauc</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>1-25-07</u>		<b>9. AGE</b> (In years last birthday) <u>54</u> yrs. IF UNDER 1 YEAR: Months Days Hours Min.					
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Plumber</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Crawford Co.</u>				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Maryland</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>									
<b>13. FATHER'S NAME</b> <u>George Esworthy</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Grace Curtis</u>									
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>				<b>16. SOCIAL SECURITY NO.</b> <b>17. INFORMANT</b> <u>Wife - Mrs. Helen Esworthy - same as above</u> Address									
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <table style="width: 100%;"> <tr> <td colspan="4"> <b>PART I. DEATH WAS CAUSED BY:</b>  <b>IMMEDIATE CAUSE (a)</b> <u>431X Congestive heart failure</u>  <b>CONDITIONS, if any, which gave rise to immediate cause (e), stating the underlying cause last.</b> <u>Myocarditis, toxic</u>  <b>DUE TO (b)</b>  <b>DUE TO (c)</b> </td> <td colspan="2" style="vertical-align: top;"> <b>INTERVAL BETWEEN ONSET AND DEATH</b>  <u>1 day</u>  <u>unknown</u> </td> </tr> </table>								<b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <u>431X Congestive heart failure</u> <b>CONDITIONS, if any, which gave rise to immediate cause (e), stating the underlying cause last.</b> <u>Myocarditis, toxic</u> <b>DUE TO (b)</b> <b>DUE TO (c)</b>				<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>1 day</u> <u>unknown</u>	
<b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <u>431X Congestive heart failure</u> <b>CONDITIONS, if any, which gave rise to immediate cause (e), stating the underlying cause last.</b> <u>Myocarditis, toxic</u> <b>DUE TO (b)</b> <b>DUE TO (c)</b>				<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>1 day</u> <u>unknown</u>									
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)</b> <u>Bronchopneumonia</u>													
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)									
<b>20c. TIME OF INJURY</b> Hour e.m. p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)							
<b>21. I certify that (I) (this hospital)</b> attended the deceased from <u>Jan 24, 1961</u> , to <u>Feb. 10, 1961</u> , that (I) <del>(we)</del> last saw the deceased alive on <u>Feb. 10, 1961</u> , and that death occurred at <u>9:25 P.M.</u> from the causes and on the date stated above.													
<b>22a. SIGNATURE</b> <u>Eino MacG</u>				<b>ATTENDING PHYS.</b> <input type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/> <b>22d. ADDRESS</b> <u>918 Univ. Blvd. E., Silver Spring, Md.</u>		<b>22b. DATE SIGNED</b> <u>2/11/61</u>							
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>EINO MACG</u>				<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>									
<b>23b. DATE THEREOF</b> <u>Feb. 14, 1961</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>George Washington Cemetery</u>		<b>23d. LOCATION (City, town or county)</b> <u>Prince Geo. Co. Md.</u>		<b>24. FURNAL DIRECTOR'S SIGNATURE</b> <u>J. Arthur Walters, 254 Canal St. NW. DC.</u>							
<b>25a. REC'D BY REGISTRAR</b> DATE <u>FEB 14 '61</u>				<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kraus</u>									

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and on any event, within 72 hours after death.

2078

1

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Hypocenters, etc.

Geometric

Feb 10 61  
Mar 24 61  
Feb 10 61

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FIVE

ONE  
FIVE

2079

## CERTIFICATE OF DEATH

Reg. Dist. No. 02056

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>		c. LENGTH OF STAY IN 1b <u>10 YRS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>		20	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8513 BARRON ST.</u>				d. STREET ADDRESS <u>8513 BARRON ST.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>SAM</u> Middle <u>-</u> Last <u>FISCHER</u>				4. DATE OF DEATH Month <u>FEBRUARY</u> Day <u>8</u> Year <u>1961</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAY 10, 1898</u>	
9. AGE (In years last birthday) <u>62</u> yrs.		IF UNDER 1 YEAR Months <u>02</u> Days <u>02</u> Hours <u>02</u> Min.		IF UNDER 24 HRS. Months <u>02</u> Days <u>02</u> Hours <u>02</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MERCHANT</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>ROMANIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>BENJAMIN FISCHER</u>				14. MOTHER'S MAIDEN NAME <u>PAULINE ARONOWITZ</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>WIFE</u>		INFORMANT <u>WIFE</u>		Address <u>8513 BARRON ST. TAKOMA</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMATOSIS</u> <u>153.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CARCINOMA OF COLON</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>3 YRS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>DIABETES MELLITUS</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>JAN. 1</u> , 19 <u>57</u> , to <u>FEB. 8</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>FEB. 6</u> , 19 <u>61</u> , and that death occurred at <u>4 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____							
ACTUAL SIGNATURE <u>Saul Zuckerman</u>				M.D. <u>5410 CONNECTICUT AVE</u> <u>2-8-61</u>			
PHYSICIAN'S NAME (Type) <u>SAUL ZUCKERMAN, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2-10-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BETH SHOLOM CEMETERY</u>		22d. LOCATION (City, town, or county) <u>HILLSIDE</u> (State) <u>MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. DANZANSKY &amp; SONS</u>				ADDRESS <u>3501-14 ST. N.W.</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 14 '61</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

5053

10-10-1914

Blank form with horizontal lines for text entry.



Page 4  
TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. **02057**

2080

1. PLACE OF DEATH a. COUNTY <b>Montg., MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montg</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Germantown</b>		c. LENGTH OF STAY IN 1b <b>2Yr 4Mo</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Marylander.Home of Rest</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Marian</b> Middle <b>Frailley</b> Last <b>Frailley</b>		4. DATE OF DEATH Month <b>Feb</b> Day <b>25</b> Year <b>1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec 12-1872</b>
9. AGE (In years last birthday) <b>88 yrs.</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>2</b> Days <b>13</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Md.</b>	
11. BIRTHPLACE (State or foreign country) <b>U S A</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
INFORMANT <b>Records. Montg.Co, Welfare Board.</b>		Address <b>Rockville.Md.</b>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchial Pneumonia</b> <b>334X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <b>Stroke, Rt. Hemiplegia</b> (c) <b>Cerebral Arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 days</b> <b>60 days</b> <b>4 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from <b>May</b> , 19 <b>59</b> , to <b>25 Feb</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>23 Feb</b> , 19 <b>61</b> , and that death occurred at <b>7:15</b> A.M. from the causes and on the date stated above.	
ACTUAL SIGNATURE <b>Gordon Smith</b>	DATE SIGNED <b>25 Feb 61</b>
PHYSICIAN'S NAME (Type) <b>Gordon Smith</b>	ADDRESS (Street, city or town, state) <b>Barnesville, Md</b>

22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>3-1-61</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>	22d. LOCATION (City, town, or county) (State) <b>Arlington Va.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ernest C. Gartner. Gaithersburg. Md.</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 2 '61</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>

3820

RECORD

CHITRAKUT

THE "CHITRAKUT" BOOK OF 1902

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

62058

2081

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b> c. LENGTH OF STAY IN 1b <b>4 years</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>4522 Dorset Avenue</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>55 Chevy Chase</b> d. STREET ADDRESS <b>4522 Dorset Avenue</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>3. NAME OF DECEASED</b> (Type or print) <b>Anna L Freeman</b>				<b>4. DATE OF DEATH</b> Month <b>February</b> Day <b>11</b> Year <b>19 61</b>											
<b>5. SEX</b> <b>Female</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>July 26, 1888</b>		<b>9. AGE</b> (In years last birthday) <b>72</b> yrs. <table border="1"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> </tr> <tr> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months	Days	Hours	Min.
IF UNDER 1 YEAR	IF UNDER 24 HRS.														
Months	Days														
Hours	Min.														
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>-----</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Washington, D. C.</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>							
<b>13. FATHER'S NAME</b> <b>Charles E. Poole</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Laura Hays</b>											
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b>				<b>16. SOCIAL SECURITY NO.</b> <b>yes Unknown</b>		<b>17. INFORMANT</b> <b>William E. Freeman-son-same 2d</b>			Address						
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>420.1</b> DUE TO <b>Acute Myocardial Infarction</b> <b>Coronary Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c)								INTERVAL BETWEEN ONSET AND DEATH <b>14 days</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)															
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)											
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b>		<b>(County)</b> <b>(State)</b>							
<b>21. I certify</b> that (I) (this hospital) attended the deceased from <b>1/29/61</b> to <b>2/11/61</b> , that (I) <del>was</del> last saw the deceased alive on <b>2/10/61</b> , and that death occurred <b>2/11/61</b> from the causes and on the date stated above.															
<b>22a. SIGNATURE</b> <b>E. Stuart Lyddane</b> M.D.				<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <b>2/11/61</b>									
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>E. Stuart Lyddane</b>				<b>22d. ADDRESS</b> <b>3066 Q St. N. W., Wash. D. C.</b>											
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>2/14/61</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Monocacy Cemetery</b>		<b>23d. LOCATION</b> (City, town or county) <b>Beallsville, Maryland</b> (State)									
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Robert A. Pumphrey</b>				<b>ADDRESS</b> <b>Bethesda, Maryland</b>		<b>25a. REC'D BY REGISTRAR</b> <b>FEB 15 '61</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur L. Kraus</b>							

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be obtained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
 15M 9/60

5081

4222 Dorset Avenue

4222 Dorset Avenue

Oct 20, 1988

Oct 20, 1988

Washington, D.C.

Washington, D.C.

Dear Mr. [illegible]

Dear Mr. [illegible]

Very truly yours,

Robert J. Monahan, Secretary  
Department of Health and Human Services

1/28/89 2/11

*[Signature]*

Robert J. Monahan

Secretary, Department of Health and Human Services

Secretary, Department of Health and Human Services

Secretary, Department of Health and Human Services

Department of Health and Human Services

Department of Health and Human Services

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## 2082 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02059

<b>1. PLACE OF DEATH</b> a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b> c. LENGTH OF STAY IN 1b <b>10 Months</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>218 HILLSBORO DRIVE</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b> d. STREET ADDRESS <b>1320 E 33rd STREET</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <b>Elizabeth C. Gleie</b>		<b>4. DATE OF DEATH</b> Month <b>FEB.</b> Day <b>18</b> Year <b>19 61</b>					
<b>5. SEX</b> <b>FEMALE</b>	<b>6. COLOR OR RACE</b> <b>WHITE</b>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>Jan. 12, 1881</b>	<b>9. AGE</b> (In years last birthday) <b>80</b> yrs. IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Own home</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Baltimore, Maryland</b> <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>			
<b>13. FATHER'S NAME</b> <b>Marion Valentine Martin</b>			<b>14. MOTHER'S MAIDEN NAME</b> <b>Anna Marion Grieb</b>				
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>NONE</b>		<b>17. INFORMANT</b> <b>Mrs Bernard Simon</b> Address <b>218 Hillsboro Dr. S. S.</b>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO <b>42001</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertension</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____					INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b> <b>years</b>		
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. _____ p.m. _____ 19 _____	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town)</b> (County) (State)				
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> <b>Accident</b> <input type="checkbox"/> <b>Suicide</b> <input type="checkbox"/> <b>Homicide</b> <input type="checkbox"/> <b>Undetermined manner</b> <input type="checkbox"/> <b>ACTUAL SIGNATURE</b> <i>Frank J. Broschart</i> <b>M.D.</b> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>EXAMINER'S NAME</b> (Type) <b>FRANK J. BROSCART</b> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <b>DATE SIGNED</b> <b>FEB 19-61</b>							
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>BURIAL</b>	<b>22b. DATE THEREOF</b> <b>2/21/61</b>	<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>BALTIMORE CEMETERY</b>	<b>22d. LOCATION</b> (City, town, or country) (State) <b>BALTIMORE, MARYLAND</b>				
<b>23. FUNERAL DIRECTOR</b> <b>WARNER E. PUMPHREY, INC.</b> ADDRESS <b>SILVER SPRING, MD.</b> <i>Raymond W. Ziska</i>		<b>24a. REC'D BY REGISTRAR</b> <b>DATE FEB 23 '61</b>	<b>24b. REGISTRAR'S SIGNATURE</b> <i>Arthur L. Hines</i>				

MEDICAL CERTIFICATION

2002

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*Handwritten signature*

*Handwritten signature*

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TO HOSPITAL OR FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed in 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Pages 3 and 4 may be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

Dr. Brochert was contacted item 3 FilmG282 3-3-61 et

02061

1. PLACE OF DEATH  
a. COUNTY Montgomery MARYLAND  
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park  
c. LENGTH OF STAY IN lb 2 hrs.  
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington Sanitarium & Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)  
a. STATE Maryland b. COUNTY Montgomery  
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville  
d. STREET ADDRESS 1307 Patton Place  
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) Robert Albert Gonano  
First Middle Last  
4. DATE OF DEATH February 24 1961  
Month Day Year

5. SEX Male 6. COLOR OR RACE White 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ 8. DATE OF BIRTH 5-25-97 9. AGE (In years last birthday) 63 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accountant 10b. KIND OF BUSINESS OR INDUSTRY Construction Co. 11. BIRTHPLACE (County & State, or foreign country) Italy 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Christopher Conane 14. MOTHER'S MAIDEN NAME Romano

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) Yes (If yes give year(s) of service) WWI 16. SOCIAL SECURITY NO. MISS MARGARET GONANO - 705 18th St, N.W. 17. INFORMANT Daughter Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Aneurysm, Ascending Aorta, Dissecting DUE TO CARDIAC TAMPONADE  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) (c)  
INTERVAL BETWEEN ONSET AND DEATH 3 HRS  
3 HRS

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 FEB 24 1961 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from FEB 24 1961 to FEB 24 1961, that (I) (we) last saw the deceased alive on FEB 24 1961, and that death occurred at 11:25 A M, from the causes and on the date stated above.

22a. SIGNATURE Edward A. Beeman M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ 22b. DATE SIGNED FEB 24 1961  
22c. PHYSICIAN'S NAME (Type) EDWARD A. BEEMAN 22d. ADDRESS 10620 GEORGIA AVE, SILVER SPRING, MD

23a. BURIAL, CREMATION, REMOVAL (Specify) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State)

24. FUNERAL DIRECTOR'S SIGNATURE Lydon Wheeler ADDRESS 1331 E. Montgomery Ave. Rockville Md 25a. REC'D BY REGISTRAR DATE FEB 27 '61 25b. REGISTRAR'S SIGNATURE Arthur S. Hines

5088

5088

CARDIAC TAMPONADE

DATE 2/23/74

FEB 24 11 24 AM '74

FEB 24 11 24 AM '74

Edward A. Berman  
Edward A. Berman

Shirley 253016  
1000 6000 1000

Shirley 253016  
1000 6000 1000

1  
FOR STATE  
HEALTH DEPT.

EXAMINER: This certificate should be executed within 24 hours after death. If any, 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>					b. COUNTY <b>St. Marys</b>				
c. LENGTH OF STAY IN 1b <b>DOA</b>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>California</b>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>U. S. Naval Hospital</b>					d. STREET ADDRESS <b>Barringer Drive</b>				
3. NAME OF DECEASED (Type or print) <b>James Allen GORDON</b>					4. DATE OF DEATH Month <b>February</b> Day <b>10</b> Year <b>19 61</b>				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Caucasian</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1-19-59</b>		9. AGE (In years last birthday) <b>2</b> yrs. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Ronald D. GORDON</b>					14. MOTHER'S MAIDEN NAME <b>Joan STEPHEN</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give year or dates of service)					16. SOCIAL SECURITY NO. <b>None</b>				
					17. INFORMANT Address <b>(F) R. D. Gordon, same as #2 above</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral edema</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Fracture skull</b> DUE TO (c)									INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Run over by milk truck in driveway of home.</b>					
2Dc. TIME OF INJURY Hour a.m. <b>11:30xx</b>		Month, Day, Year <b>2-10-61</b>		2Dd. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Driveway -Home</b>		2Df. (City or town) (County) (State) <b>California St. Marys Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>Frank J. Broschart</i>					CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <b>Frank J. BROSCHART, M. D.</b>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
					DATE SIGNED <b>2-10-61</b>				
					Address (Street, city, town, or county) <b>Gaithersburg, Md.</b>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/13/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>			22d. LOCATION (City, town, or country) (State) <b>Arlington, Virginia</b>		
23. FUNERAL DIRECTOR <i>Robinson</i> <b>Robinson Funeral Home, Leonardtown, Md.</b>					24a. REC'D BY REGISTRAR DATE <b>FEB 14 '61</b>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Hanna</i>		

02062

5088

California

U. S. Naval Hospital

Barringer Drive

California

CORDON

1-12-52

John STEPHEN

Howard D. G. HUGH

(F) R. D. Gordon, used as S. Moore

Run over by milk truck in driveway of home.

11:30xx 2-10-51

Highway - Home

Frank J. BROCKHART, M. D.

Washington National

2-10-51

Initial

Howard D. G. HUGH

Arlington, Virginia



**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

02063

2086

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Washington DC.</u> b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington Gardens Sanatorium</u>			d. STREET ADDRESS <u>477 X St</u>		
3. NAME OF DECEASED (Type or print) First <u>Annie</u> Middle <u>E</u> Last <u>Griffin</u>			4. DATE OF DEATH Month <u>Feb.</u> Day <u>12</u> Year <u>1961</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2 April 1880</u>	9. AGE (In years lost birthday) <u>80</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>USA - Brooklyn, NY</u>	
13. FATHER'S NAME <u>Joseph Pfirman</u>			14. MOTHER'S MAIDEN NAME <u>Elizabeth Hoff</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT <u>Home Records</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CEREBRAL VASCULAR ACCIDENT (THROMBOSIS)</u> DUE TO (c) <u>CEREBRAL VASCULAR ARTERIOSCLEROSIS</u>					INTERVAL BETWEEN ONSET AND DEATH <u>20 MINUTES</u> <u>48 HOURS</u> <u>10 YEARS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>SQUAMOUS CELL CARCINOMA OF VULVA</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>NOV 2 1959</u> to <u>FEB 11 1961</u> , that (I) ( <del>was</del> ) last saw the deceased alive on <u>FEB 11 1961</u> , and that death occurred at <u>5:30 PM</u> from the causes and on the date stated above.					
22a. SIGNATURE <u>Joseph D. Connor</u>		M.D. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>FEB 13 1961</u>
22c. PHYSICIAN'S NAME (Type) <u>JOSEPH D. CONNOR, M.D.</u>		22d. ADDRESS <u>9420 OLD GEORGETOWN RD Bethesda 14, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>2/14/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt Olive Cem.</u>	23d. LOCATION (City, town, or county) (State) <u>Washington DC</u>		
24. FUNERAL DIRECTOR'S SIGNATURE <u>Cheng Chare Funeral Home, Wash. DC</u>		ADDRESS <u>5103 Wis Ave NW</u>	25a. REC'D BY REGISTRAR <u>FEB 14 '61</u>	25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

5088

CERTIFICATE OF DEATH

STATE DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
BOSTON, MASSACHUSETTS

1912

0

James J. [illegible]

1912

Attest: [illegible]

1912

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

2087

02064

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b> c. LENGTH OF STAY in 1b <b>2 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Washington Sanitarium &amp; Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b> d. STREET ADDRESS <b>10108 Pierce Drive</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Fannie</b> First <b>SCHUM</b> Middle <b>Womer</b> Last <b>Hannum</b>		4. DATE OF DEATH Month <b>February</b> Day <b>10</b> Year <b>1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 20, 1882</b> Yrs. <b>78</b> Months Days Hours Min.
9. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Frank Schum</b>		14. MOTHER'S MAIDEN NAME <b>Fannie Womer</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Washington Sanitarium and Hospital Records</b>		Address <b>7600 Carroll Ave. Takoma Park</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>420-1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary sclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Congestive heart failure</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour e.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Feb. 2, 1961</b> to <b>Feb. 10, 1961</b> , that (I) (we) last saw the deceased alive on <b>Feb. 9, 1961</b> , and that death occurred at <b>4:15 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>A. F. THIBADEAU</b>		22b. DATE SIGNED <b>2/10/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>A. F. THIBADEAU</b>		22d. ADDRESS <b>10111 Colesville Rd. SILVER SPRING, MD.</b>	
23a. BURIAL, CREMATION, TRANS. & REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>2/13/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>HOMEWOOD CEMETERY</b>		23d. LOCATION (City, town or county) (State) <b>PITTSBURG, PENNSYLVANIA</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond E. Ziska</b>		25a. REC'D BY REGISTRAR DATE <b>FEB 14 '61</b>	
ADDRESS <b>SILVER SPRING, MD.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>	

TO HOSPITAL OR FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

305

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2088

## CERTIFICATE OF DEATH

02065

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>Derwood</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) d. STREET ADDRESS <u>Derwood</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Archibald</u> Middle <u>Leonard</u> Last <u>Harris</u>		<b>4. DATE OF DEATH</b> Month <u>February</u> Day <u>28</u> Year <u>1961</u>		<b>5. SEX</b> <u>Male</u> <b>6. COLOR OR RACE</b> <u>White</u>			
<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>January 6, 1893</u> <b>9. AGE</b> (In years last birthday) <u>68</u> yrs.		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Retired</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Farmer</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>MARYLAND</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>			
<b>13. FATHER'S NAME</b> <u>EDWIN A HARRIS</u>			<b>14. MOTHER'S MAIDEN NAME</b> <u>Rebecca Elbert</u>				
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>NO</u>		<b>16. SOCIAL SECURITY NO.</b> <u>Wordna Galeano</u>		<b>17. INFORMANT</b> <u>7315 Lacona St. S.E. Washington, D.C.</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>199.2 Pelvic Abscess and Peritonitis</u> DUE TO (b) <u>Separation of uretero-sigmoid anastomosis</u> DUE TO (c) <u>Total Cystectomy for Malignancy</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)							
<b>20c. TIME OF INJURY</b> Month, Day, Year <u>19</u> Hour a.m. <u>19</u> p.m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Feb. 5 - 1961</u> , to <u>2-27-1961</u> , that (I) (we) last saw the deceased alive on <u>2-27-1961</u> , and that death occurred at <u>7:55 AM</u> , from the causes and on the date stated above.							
<b>22a. SIGNATURE</b> <u>Linwood H. Johnson Jr.</u> M.D. <b>22c. PHYSICIAN'S NAME</b> (Type) <u>Linwood H. Johnson Jr.</u>				<b>22b. DATE SIGNED</b> <b>22d. ADDRESS</b> <u>4630 Montgomery Ave, Bethesda, Md.</u> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>3-2-61</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Rockville Union</u>			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Elbert</u>		<b>24. ADDRESS</b> <u>316 E. Diamond Ave., Gaithersburg, Md.</u>		<b>25a. REC'D BY REGISTRAR</b> <u>Arthur S. Kraus</u> DATE <u>MAR 2 '61</u>			

TO HOSPITAL OR FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

2000

10

*[Faint handwritten signature]*

Robert L. Thompson



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 2089

### CERTIFICATE OF DEATH

02066

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>District of Columbia</b> b. COUNTY <b>✓</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gaithersburg</b>				c. LENGTH OF STAY IN 1b <b>Washington</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Asbury Methodist Home for the Aged, Inc.</b>				d. STREET ADDRESS <b>916 K. St., N. E.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>First</b> <b>Ida</b>		<b>Middle</b> <b>Belle</b>		<b>Last</b> <b>Harvey</b>		4. DATE OF DEATH <b>Month</b> <b>2</b> <b>Day</b> <b>2</b> <b>Year</b> <b>19 61</b>	
5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>January 6, 1880</b>	
9. AGE (In years last birthday) <b>81</b> yrs.		IF UNDER 1 YEAR Months <b>2</b> Days <b>2</b> Hours <b>19</b> Min.		IF UNDER 24 HRS. Hours <b>19</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Millgreen, Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>John Bailey Biles</b>				14. MOTHER'S MAIDEN NAME <b>Helen Jane Pyle</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>no</b>			
17. INFORMANT <b>Asbury Home records - Gaithersburg, Md.</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>443X</b> IMMEDIATE CAUSE (a) <b>Generalized Arteriosclerosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>Years.</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypertensive Cardiovascular Disease</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <b>Oct</b> , 19 <b>60</b> , to <b>Feb 2</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>Jan. 26</b> , 19 <b>61</b> , and that death occurred at <b>9:20</b> A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>7720 Wisconsin Ave.</b> DATE SIGNED _____ ACTUAL SIGNATURE <b>James W. Egan</b> M.D. <b>Bethesda Md.</b> PHYSICIAN'S NAME (Type) <b>James W. Egan, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2-4-61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Emory Church Cemetery Street.</b>		22d. LOCATION (City, town, or county) _____ (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ernest C. Gartner, Gaithersburg, Md.</b>				24a. RECEIVED BY REGISTRAR <b>FEB 6 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be released by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2089

TESTIFICATE OF DEATH

STATE OF MICHIGAN

John Edgar Biles  
Baltimore, Maryland

John Edgar Biles  
Baltimore, Maryland

Admited to the home for the aged, Inc.

John Edgar Biles

Baltimore, Maryland

January 6, 1930

Michigan, MI.

John Edgar Biles

Admited to the home for the aged, Inc.

MI.

Page 4  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
may be released by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

1  
2090  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

02067

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b>		c. LENGTH OF STAY IN 1b <b>32 DAYS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MONTGOMERY GENERAL HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>RUFUS</b> Middle <b>KING</b> Last <b>HELPHENSTINE JR</b>		4. DATE OF DEATH Month <b>FEBRUARY</b> Day <b>17</b> Year <b>19 61</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-25-1882</b>
9. AGE (In years last birthday) <b>78</b> yrs.		10. IF UNDER 1 YEAR Months <b>20</b> Days <b>11</b> Hours <b>11</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FORRESTER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>WASHINGTON, D. C.</b>	
11. BIRTHPLACE (State or foreign country) <b>WASHINGTON, D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>RUFUS KING HELPHENSTINE</b>		14. MOTHER'S MAIDEN NAME <b>LAURA PLANT</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>(If yes, give war or dates of service)</b>		16. SOCIAL SECURITY NO. <b>217-36-8616</b>	
17. INFORMANT <b>HOSPITAL RECORDS, OLNEY, MARYLAND</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL METASTASIS</b> DUE TO <b>CHRONIC RENAL FAILURE</b> DUE TO <b>BROCHIOGENIC CARCINOMA</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>TWO MONTHS</b> <b>SIX MONTHS</b> <b>ONE MONTH</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>JANUARY 10 1961</b> to <b>FEBRUARY 17 1961</b> , that (I) (we) last saw the deceased alive on <b>FEBRUARY 16 1961</b> , and that death occurred at <b>9:20 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>G. S. ROSENBERGER, M. D.</b>		22b. DATE <b>FEB 17 1961</b>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <b>ROCKVILLE, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/20/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Glenwood</b>		23d. LOCATION (City, town, or county) (State) <b>Washington, D.C.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Tyson Wheeler Funeral Home</b>		25a. REC'D BY REGISTRAR <b>FEB 20 '61</b>	
ADDRESS <b>1231 E. Montg. Ave., Rockville, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

2038

CERTIFICATE OF DEATH

HOSPITALITY

HOSPITALITY

CLERK

35 DAYS

RECOVERED

HOSPITALITY GENERAL HOSPITAL

18 MILLMAN STREET

WHITE

WHITE

REPRESENTATIVE US

FEBRUARY 17, 1918

DATE

WHITE

9-25-1-02

55

FOREIGNER

WASHINGTON, D. C.

1918

RECORDS SECTION

LAURA CLARK

HOSPITAL RECORDS, WINNEY, WISCONSIN

GENERAL HISTORY

History of Present Illness

Pathologic Examination

Page 1

Page 1

RECORDS SECTION

RECORDS SECTION

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. Pages 3 and 4 may be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
2091  
CERTIFICATE OF DEATH

02068

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN b <b>51 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>U. S. Naval Hospital</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Arrington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>82X-3</b> d. STREET ADDRESS <b>RFD</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
3. NAME OF DECEASED (Type or print) <b>Russell</b> <b>Massie</b> <b>HENDERSON</b>		4. DATE OF DEATH Month <b>February</b> Day <b>17</b> Year <b>19 61</b>		5. SEX <b>Male</b>		6. COLOR OR RACE <b>Caucasian</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9-20-34</b>		9. AGE (In years last birthday) <b>26</b> yrs.		10. IF UNDER 1 YEAR Months <b>26</b>		11. IF UNDER 24 HRS. Days <b>26</b>		12. Hours <b>26</b>		13. Min. <b>26</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Officer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Navy</b>				11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>									
13. FATHER'S NAME <b>Elmo Ward HENDERSON</b>				14. MOTHER'S MAIDEN NAME <b>Virginia Lucille SAUNDERS</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes</b>				16. SOCIAL SECURITY NO. <b>231-38-0860</b>				17. INFORMANT <b>(W) Mrs. Juanita W. Henderson, same as #2 above</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA, EMBRYONAL, WITH METASTASES</b> 199.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (this hospital) attended the deceased from <b>Dec. 28, 1960</b> to <b>Feb. 17, 1961</b> that (we) last saw the deceased alive on <b>Feb. 17, 1961</b> , and that death occurred at <b>4:25 AM</b> , from the causes and on the date stated above. 22a. SIGNATURE <b>H. Hubbard</b> 22b. DATE SIGNED <b>2-17-61</b> 22c. PHYSICIAN'S NAME (Type) <b>H. HUBBARD, CDR, MC, USN</b> 22d. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b> 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 23b. DATE THEREOF <b>2-19-61</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Family Cemetery</b> 23d. LOCATION (City, town or county) (State) <b>Piney River Virginia</b> 24. FUNERAL DIRECTOR'S SIGNATURE <b>John W. Demaines</b> 25a. REC'D BY REGISTRAR <b>FEB 20 '61</b> 25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>																					

1005

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U.S. DEPARTMENT OF AGRICULTURE

10-11-12

*(Signature)*





2002

Director of Columbia

Washington

Mr. [Name]

Belmont

The Criminal Center, Federal Bldg., 2nd Floor, New York, N.Y.

Washington

Attorney

William

NY 100

File

NY 100

State Police

File

NY 100

John J. [Name]

The Criminal Center

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The Criminal Center, Federal Bldg., 2nd Floor, New York, N.Y.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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15M 9/59

2093

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

02070

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>				c. LENGTH OF STAY IN 1b <u>35</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3913 Hampden Street.,</u>				d. STREET ADDRESS <u>3913 Hampden</u>			
				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>CORA</u> Middle <u>ALICE</u> Last <u>HIGGINS</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>25</u> Year <u>1961</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 7, 1865</u>	
				9. AGE (In years lost birthday) <u>95</u> yrs.		IF UNDER 1 YEAR Months <u>2</u> Days <u>18</u> Hours <u></u> Min. <u></u>	
						IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>George Spinner</u>				14. MOTHER'S MAIDEN NAME <u>Mary J. (unknown)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Mrs. Lillie Cohen</u> Address <u>3913 Hampden St., Kensington, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.2</u> DUE TO <u>Chronic Myocarditis (Senile)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Chronic Interstitial Nephritis</u> (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE/CONDITION GIVEN IN PART I (a) <u></u>				INTERVAL BETWEEN ONSET AND DEATH <u>1952(?)</u> <u>1955?</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	
				20f. (City or town) <u></u>		(County) <u></u> (State) <u></u>	
21. I certify that (I) (this hospital) attended the deceased from <u>June</u> 19 <u>54</u> , to <u>Feb. 25</u> 19 <u>61</u> , that (I) <u>(was)</u> last saw the deceased alive on <u>2-24</u> 19 <u>61</u> and that death occurred at <u>2</u> PM, from the causes and on the date stated above.							
22a. SIGNATURE <u>Calvin B. LeCompte</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>2/25/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Calvin B. LeCompte</u>				22d. ADDRESS <u>61 R. St. NE Wash DC</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/25/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Memorial.,</u>		23d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Snowden</u>				ADDRESS <u>Rockville, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>MAR 2 '61</u>	
						25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

1992

[Illegible text]

2094

CERTIFICATE OF DEATH

Reg. Dist. No. 02071

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>5902 Sonoma Road</b>		d. STREET ADDRESS <b>5902 Sonoma Road</b>	
3. NAME OF DECEASED (Type or print) <b>Gizela</b> First Middle Last <b>Hild</b>		4. DATE OF DEATH Month <b>February</b> Day <b>20</b> Year <b>19 61</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/14/1876</b>
9. AGE (In years last birthday) yrs. <b>84</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Roumania</b>		12. CITIZEN OF WHAT COUNTRY? <b>Roumania</b>	
13. FATHER'S NAME <b>Ludwig Hesshaimer</b>		14. MOTHER'S MAIDEN NAME <b>Julia Lassel</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Charles Hild</b>		Address <b>Bethesda Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>420.1</b> IMMEDIATE CAUSE (a) <b>Respiratory Failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Thrombosis</b> DUE TO (c) <b>Generalized Hypertension &amp; Atherosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs.</b> <b>2 days</b> <b>5 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>12/7</b> , 19 <b>60</b> , to <b>2/20</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>2/18</b> , 19 <b>61</b> , and that death occurred at <b>8:45 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>S. A. Thomas</b>		ADDRESS (Street, city or town, state) <b>4301 48th St. NW Washington D.C.</b>	
DATE SIGNED			
PHYSICIAN'S NAME (Type) <b>S. A. Thomas M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>cremation 2/20/61</b>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Crematory</b>		22d. LOCATION (City, town, or county) (State) <b>Prince Georges Co. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S. H. Hines Co.</b>		ADDRESS <b>Washington, D. C.</b>	
24a. REC'D BY REGISTRAR <b>FEB 21 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in. The funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

2095

02072

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wheaton Nursing Home</u>				d. STREET ADDRESS <u>110906-Oakwood St.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Leon</u> First <u>N</u> Middle <u>Hirschman</u> Last		4. DATE OF DEATH <u>Feb.</u> Month <u>6</u> Day <u>19</u> Year <u>61</u>					
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 14, 1885</u>	9. AGE (In years lost birthday) <u>75</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Behr Hirschman</u>				14. MOTHER'S MAIDEN NAME <u>Blume</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Behr Hirschman</u> Address <u>10906-Oakwood St. Silver Spring, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420 Congestive Heart Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Artery Disease</u> DUE TO (c) <u>Gen. Arteriosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>6 wks.</u> <u>3 yrs.</u> <u>5 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 2, 1961</u> to <u>Feb 6, 1961</u> , that (I) (we) last saw the deceased alive on <u>Feb 6, 1961</u> , and that death occurred at <u>11:30 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Armand B. Gordon</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>2/6/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Armand B. Gordon, M.D.</u>				22d. ADDRESS <u>2828 Conn. Ave. N.W., Wash. 8, D.C.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>FEB 8, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>BALTIMORE HEBREW</u>		23d. LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Sol. Levinson &amp; Bros. Inc. 6010 Reist Road</u>				ADDRESS		25a. REC'D BY REGISTRAR <u>FEB 14 '61</u> DATE	
				25b. REGISTRAR'S SIGNATURE <u>Arthur S. H...</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with the attending physician and completely filled in by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

5002

CERTIFICATE OF DEATH

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CRIMINAL JUSTICE

INVESTIGATION

RECORDS SECTION

ADMINISTRATIVE

RECORDS SECTION

ADMINISTRATIVE

TO HOSPITAL OR FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certain papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed in 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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M  
Dr. Frank Broschart contacted + gave permission to Dr. M. Romanovsky to certify death

Item 19-111m 289  
6-27-61 ams  
2096

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02073

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b> c. LENGTH OF STAY in 1b <b>D.O.A.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Wash. San &amp; Hosp</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b> d. STREET ADDRESS <b>1510 Oakview Drive</b>	
3. NAME OF DECEASED (Type or print) First <b>Moe</b> Middle <b>nmn</b> Last <b>Hirschttritt</b>		4. DATE OF DEATH Month <b>2</b> Day <b>5</b> Year <b>1961</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>Wh</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>Nov. 30, 1915</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Gov. Employed</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Dept of Health Education &amp; Welfare</b>	9. AGE (In years last birthday) <b>45</b> IF UNDER 1 YEAR: Months <b>0</b> Days <b>0</b> IF UNDER 24 HRS.: Hours <b>0</b> Min. <b>0</b>
11. BIRTHPLACE (County & State, or foreign country) <b>NEW YORK, N.Y.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>ISAAC Hirschttritt</b>		14. MOTHER'S MAIDEN NAME <b>Ida HIRSHMAN</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>Yes 1942-46</b>		16. SOCIAL SECURITY NO. <b>RALPH HIRSCHTRITT-1712 REPUBLIC RD.</b>	
17. INFORMANT <b>S.S. Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Probably Coronary Occlusion</b> 420 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>immediate</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>past history of hypertension</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. <b>19</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>about 6 weeks ago</b> 19... that (I) (we) last saw the deceased alive on <b>about 6 weeks ago</b> 19... and that death occurred at <b>about 10:30-10:45 AM</b> 19... from the causes and on the date stated above.			
22a. SIGNATURE <b>monroe J. Romanovsky</b> M.D.		22b. DATE SIGNED <b>George Wash Univ. Hosp.</b>	
22c. PHYSICIAN'S NAME (Type) <b>Monroe J. Romanovsky</b>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>FEB. 7-1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>BETH DAVID CEMETERY</b>	23d. LOCATION (City, town or county) (State) <b>LONG ISLAND - N.Y.</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Bernard Langworthy &amp; Sons - 3501-14th St</b>		25a. REC'D BY REGISTRAR <b>FEB 7 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. House</b>			

2013

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2097

## CERTIFICATE OF DEATH

02074

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>13 hrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>X German Town</u> d. STREET ADDRESS <u>1 Route 1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Baby Girl HITT</u>				<b>4. DATE OF DEATH</b> Month <u>Feb.</u> Day <u>26</u> Year <u>1961</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 25, 1961</u>	
9. AGE (In years last birthday) <u>13</u>		IF UNDER 1 YEAR Months <u>13</u> Days <u>13</u>		IF UNDER 24 HRS. Hours <u>13</u> Min. <u>13</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Montgomery Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Jack HITT, Jr.</u>	
14. MOTHER'S MAIDEN NAME <u>Robin Burris</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Robin Hitt</u> Address <u>Route 1 German Town, Md.</u>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Subdural hemorrhage</u> 760.5 DUE TO <u>Pneumonia (?)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>—</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>MEDICAL CERTIFICATION</b> 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u> 20c. TIME OF INJURY Month, Day, Year <u>19</u> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u> 20f. (City or town) <u>—</u> (County) <u>—</u> (State) <u>—</u> 21. I certify that (I) (this hospital) attended the deceased from <u>2-25-61</u> to <u>2-26-61</u> , that (I) (we) last saw the deceased alive on <u>2-26-61</u> , and that death occurred at <u>8:00 PM</u> , from the causes and on the date stated above. 22a. SIGNATURE <u>Ira Pearlman</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>—</u> 22c. PHYSICIAN'S NAME (Type) <u>Ira Pearlman</u> 22d. ADDRESS <u>4700 Bradley Blvd, Bethesda, Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/28/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Forest Oak</u>		23d. LOCATION (City, town or county) <u>Gaithersburg, Maryland</u> (State) <u>—</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Tyson Wheeler</u> ADDRESS <u>Funeral Home-1331 E. Montg. Ave. Rockville, Maryland</u>				25a. REC'D BY REGISTRAR <u>—</u> DATE <u>MAR 1 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1985

Initial: [illegible]  
Lyon Wheeler, United States-1981, [illegible]  
Rockville, Maryland



VS. A15ME  
5M 7/59

**MARYLAND STATE DEPARTMENT OF HEALTH**

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2098 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02075

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montg.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>721 Ritchie Ave.</b>		d. STREET ADDRESS <b>721 Ritchie Ave.</b>	
3. NAME OF DECEASED (Type or print) <b>Clarence Norman Hohenberger</b>		4. DATE OF DEATH Month <b>Feb.</b> Day <b>10,</b> Year <b>1961</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/24/1900</b>
9. AGE (In years, birth day) <b>60</b> yrs.		10. IF UNDER 1 YEAR Months <b>6</b> Days <b>19</b>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Railway Exp. agency</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Henry Hohenberger</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Fannie Hohenberger *</b>		Address <b>Item 2</b>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>a.m.</b> <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Frank J. Broschart</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, DATE THEREOF <b>Burial Feb. 13, 1961</b>		22b. NAME OF CEMETERY OR CREMATORY <b>Cesar Hill Cemetery</b>	
23. FUNERAL DIRECTOR <b>J. Arthur Walters, 254 Canal St NW DC</b>		24a. REC'D BY REGISTRAR <b>DATE FEB 14 '61</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Thomas</b>		25. ADDRESS (Street, city, town, or county) <b>Prince Geo. Co. Md.</b>	

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# 1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
2100 MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
Item 8 Film G281 2-24-61 et									
02077									
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>DOA</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Suburban Hospital</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Ma ryland</b> b. COUNTY <b>Montg.</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rockville</b> d. STREET ADDRESS <b>402 S. Horners Lane</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>Henry Jackson Hunt</b>					4. DATE OF DEATH <b>Feb. 16</b> 19 <b>61</b>				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12/9/08/1909</b>		9. AGE (In years last birthday) <b>51</b> yrs. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Home Owner</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Dog Kennels</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Henry J. Hunt</b>					14. MOTHER'S MAIDEN NAME <b>ROSE WARDER</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give year or dates of service)					16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>5225 Westpath Way, Sumner, Md. John Hunt Bethesda, Md. (Brother)</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage &amp; laceration</b> DUE TO (b) <b>Bullet wound in rt skull</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)									
INTERVAL BETWEEN ONSET AND DEATH <b>1/2 hr.</b>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <b>self inflicted bullet wound</b>				
20c. TIME OF INJURY <b>8:30</b> <input checked="" type="checkbox"/> P.M. <b>2/16/61</b>			20d. INJURY OCCURRED <b>While at work</b> <input type="checkbox"/> <b>Not While at work</b> <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>street</b>		20f. (City or town) <b>Rockville Montg</b> (County) <b>Md.</b> (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <b>Frank J. Broschart</b>					CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
					DATE SIGNED <b>2/16/61</b>				
					Address (Street, city, town, or county)				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		22b. DATE THEREOF <b>2-18-61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>		22d. LOCATION (City, town, or country) (State) <b>Prince George County, Md.</b>			
23. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY</b> ADDRESS <b>Bethesda, Md.</b>					24a. REC'D BY REGISTRAR <b>FEB 21 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>		

ep



TO THE HONORABLE SECRETARY  
OF THE AMERICAN MEDICAL ASSOCIATION  
CHICAGO, ILL.

RE: [illegible]  
[illegible]  
[illegible]



[illegible]  
[illegible]  
[illegible]

[illegible]  
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[illegible]  
[illegible]



**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

2101

02078

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>			c. LENGTH OF STAY IN lb <b>7 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brookmont</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				d. STREET ADDRESS <b>4020 - 64th Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Lina</b> Middle <b>Dorothy</b> Last <b>James</b>				4. DATE OF DEATH Month <b>February</b> Day <b>28</b> , Year <b>19 61</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>October 14, 1888</b>	
9. AGE (In years last birthday) <b>72</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Stenographer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Office</b>		11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Otto Jahn</b>				14. MOTHER'S MAIDEN NAME <b>Lina D. Stephanson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>Unascertainable</b>		17. INFORMANT <b>The Medical Records</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary Arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Lymphoma</b>						INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <b>he</b> (this hospital) attended the deceased from <b>February 21 1961</b> , to <b>February 28 19 61</b> , that <b>he</b> (we) last saw the deceased alive on <b>February 28 19 61</b> , and that death occurred at <b>10:10PM</b> from the causes and on the date stated above.							
22a. SIGNATURE <i>H. J. Gitelman</i>				22b. DATE SIGNED <b>3/1/61</b>		22c. PHYSICIAN'S NAME (Type) <b>Hillel J. Gitelman, M.D.</b>	
22d. ADDRESS <b>The Clinical Center National Institutes Of Health Bethesda 14, Maryland</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Bur-Transit</b>		23b. DATE THEREOF <b>3/3/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Geo. Wash. Mem. Park</b>		23d. LOCATION (City, town, or county) (State) <b>Paramus, New Jersey</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>				25a. REC'D BY REGISTRAR DATE <b>MAR 3 '61</b>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

CERTIFICATE OF DEATH

1015

1. Name of Deceased: [Illegible]  
2. Sex: [Illegible]  
3. Age: [Illegible]  
4. Date of Birth: [Illegible]  
5. Date of Death: [Illegible]  
6. Place of Death: [Illegible]  
7. Cause of Death: [Illegible]  
8. Signature of Physician: [Illegible]  
9. Signature of Registrar: [Illegible]  
10. Date of Registration: [Illegible]

MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

2102

02079

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park 12</u>				c. LENGTH OF STAY IN 1b <u>1 month</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Oak Haven Convalescent Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Charles O Johnson</u>				4. DATE OF DEATH Month Day Year <u>Feb 15 1961</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 29, 1877</u>		9. AGE (In years last birthday) <u>83</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Store Keeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Grocer</u>		11. BIRTHPLACE (State or foreign country) <u>Scott Co, Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>William Johnson</u>				14. MOTHER'S MAIDEN NAME <u>Fannie Benham</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>Mrs Bland Webb's 745 Eastern Ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO <u>493X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>—</u> DUE TO <u>—</u> (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis, Smiling, Recent Cerebral Vascular accident</u> 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u> 20c. TIME OF INJURY Month, Day, Year Hour o. m. — 19 p. m. <u>—</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u> 20f. (City or town) (County) (State) <u>—</u>							INTERVAL BETWEEN ONSET AND DEATH <u>24 hr.</u>
21. I certify that (I) (this hospital) attended the deceased from <u>Nov. 1956</u> to <u>15 Feb. 1961</u> , that (I) (we) last saw the deceased alive on <u>2-15-1961</u> , and that death occurred at <u>2:45 PM</u> , from the causes and on the date stated above.							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
22a. SIGNATURE <u>Frederick Barr</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <u>2-15-61</u>			
22c. PHYSICIAN'S NAME (Type) <u>J. FREDERICK BARR, MD</u>				22d. ADDRESS <u>4500 College Avenue College Park, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>—</u>		23b. DATE THEREOF <u>2/18/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ledar Hill Cem</u>		23d. LOCATION (City, town, or county) (State) <u>Geo Co Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>W. T. Huntman &amp; Son 5732 Ga Ave</u>				25a. REC'D BY REGISTRAR DATE <u>FEB 20 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
2103  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

02080

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>CONGRESSIONAL MANOR SANITARIUM</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> 45 d. STREET ADDRESS <u>9303 Bull Run Parkway</u> 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) <u>Ethel</u> First Middle Last <u>JOHNSON</u>		4. DATE OF DEATH <u>Feb</u> Month <u>18</u> Day <u>1961</u> Year		5. SEX <u>F</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JAN. 9 1881</u>		9. AGE (In years lost birthday) <u>80</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <u>Virginia</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>W. F. JOHNSON</u>				14. MOTHER'S MAIDEN NAME <u>Antitia JONES</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.				17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE CONGESTIVE HEART FAILURE</u> DUE TO (b) <u>UREMIA</u> DUE TO (c) <u>ARTERIOSCLEROTIC VASCULAR DISEASE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																INTERVAL BETWEEN ONSET AND DEATH <u>10 MINUTES</u> <u>6 MONTHS</u> <u>10 YEARS</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)																			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>NOV. 18 1960</u> to <u>FEB. 18 1961</u> , that (I) (we) lost saw the deceased alive on <u>FEB. 16 1961</u> , and that death occurred at <u>5 PM</u> , from the causes and on the date stated above.																			
22a. SIGNATURE <u>Joseph D Connor</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> <u>FEB. 18, 1961</u> 22b. DATE SIGNED																			
22c. PHYSICIAN'S NAME (Type) <u>JOSEPH D CONNOR, M.D.</u> 22d. ADDRESS <u>9420 OLD GEORGETOWN Bethesda Md.</u>																			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>				23b. DATE THEREOF <u>2/19/61</u>				23c. NAME OF CEMETERY OR CREMATORY <u>Fairview</u>				23d. LOCATION (City, town, or county) (State) <u>Culpeper Virginia</u>							
24. FUNERAL DIRECTOR'S SIGNATURE <u>Cheng Chan Funeral Home Washington DC</u> ADDRESS <u>5163 Wisconsin Ave Washington DC</u> 25a. REC'D BY REGISTRAR DATE <u>FEB 24 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>																			

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CERTIFICATE OF DEATH

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1503 8-11 Km. Highway 100 x

Col/ly

For view

Time Vol 5/18/01



Page 4  
TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
ISM 9/59

1  
MARYLAND DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
2104 CERTIFICATE OF DEATH 02081

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>65 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b> d. STREET ADDRESS <b>8217 Roanoke Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Mabelle</b> Middle <b>Pearl</b> Last <b>Johnson</b>		4. DATE OF DEATH Month <b>February</b> Day <b>12</b> Year <b>19 61</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 11, 1896</b>
9. AGE (In years last birthday) <b>62</b> yrs.		10. IF UNDER 1 YEAR Months <b>30</b> Days <b>9</b> Hours <b>12</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Illinois</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Arthur Buss</b>		14. MOTHER'S MAIDEN NAME <b>Cora Dawes</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intra abdominal hemorrhage secondary to metastatic</b> <b>1950</b> DUE TO <b>adrenal cortical carcinoma of liver</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Adrenal cortical carcinoma metastatic to lungs and</b> DUE TO <b>liver</b> (c) <b>9 Months</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>30 hours</b> INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>December 9 1960</b> to <b>February 12 1961</b> , that (I) (we) last saw the deceased alive on <b>Feb. 12 19 61</b> , and that death occurred at <b>4:40AM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Martin Nydick M.D.</b>		22b. DATE SIGNED <b>2/12/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Martin Nydick M.D.</b>		22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>		23b. DATE THEREOF <b>2/13/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Ladies Union Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Stockton, Ill.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Sh S H Jones Co, 2901-14th St, NW</b>		25a. REC'D BY REGISTRAR <b>Feb 14 61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>			

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• "I spent a lot of time in the hospital."

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6801 J. L. Lutz

Abstract: *See page 100.*

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Do you see?

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any death is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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5M 7/59

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FOR STATE  
HEALTH DEPT.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
2105 MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
02082									
1. PLACE OF DEATH a. COUNTY <u>Sadie Montgomery</u> <u>MARYLAND</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg.</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>					c. LENGTH OF STAY IN 1b <u>40 years</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>222 N. Washington St.</u>					d. STREET ADDRESS <u>222 N. Washington St.</u>				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <u>Sadie Frances Johnson</u>					4. DATE OF DEATH <u>Feb. 18, 1961</u>				
5. SEX <u>female</u>					6. COLOR OR RACE <u>col.</u>				
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH <u>5/26/1887</u>				
9. AGE (In years last birthday) <u>73</u> yrs.					IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>					10b. KIND OF BUSINESS OR INDUSTRY				
11. BIRTHPLACE (State or foreign country) <u>Va.</u>					12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				
13. FATHER'S NAME <u>Burrell Nelson</u>					14. MOTHER'S MAIDEN NAME <u>Sarah Wyatt</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u></u>					16. SOCIAL SECURITY NO. <u></u>				
17. INFORMANT <u>Geo. Johnson (husband)</u>					Address <u>Item 2</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO (b) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u></u> DUE TO (c) <u></u> INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>					20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <u>Frank J. Broschart</u>					CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
					DATE SIGNED <u>2/20/61</u>				
Address (Street, city, town, or county)									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					22b. DATE THEREOF <u>2/22/61</u>				
22c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Park Cemetery</u>					22d. LOCATION (City, town, or country) (State) <u>Rockville Md</u>				
23. FUNERAL DIRECTOR <u>Robert L. Snowden</u>					24a. REC'D BY REGISTRAR <u>Rockville, Md</u>				
ADDRESS <u>Rockville, Md</u>					24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>				
DATE <u>FEB 24 '61</u>									

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THE STATE  
OF NEW YORK

5103

CERTIFICATE OF DEATH

IN SENATE

January 1, 1900

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Secretary

Albany

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Page 4  
TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
2106  
CERTIFICATE OF DEATH  
02083

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>95 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Minnesota</b> b. COUNTY <b>Brainerd</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First Middle Last <b>Margaret Caroline Jones</b>			4. DATE OF DEATH Month Day Year <b>February 5 1961</b>												
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 1, 1908</b>		9. AGE (In years last birthday) <b>52</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Correctional Administ.</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Penal Institution</b>				11. BIRTHPLACE (State or foreign country) <b>Minnesota</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Ernest Jones</b>						14. MOTHER'S MAIDEN NAME <b>Caroline Moe</b>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Malignant Carcinoid</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs</b>												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Brainerd</b>		(County) <b>Minn.</b>		(State)			
21. I certify that (I) (this hospital) attended the deceased from <b>November 2 1961</b> to <b>February 5 1961</b> , that (I) (we) last saw the deceased alive on <b>Feb. 5 1961</b> , and that death occurred at <b>7am</b> , from the causes and on the date stated above.															
22a. SIGNATURE <b>Michael Z. Lazor</b> 22c. PHYSICIAN'S NAME (Type) <b>Michael Z. Lazor, M.D.</b>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>2/6/61</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-transit 2-7-61</b>				23b. DATE THEREOF <b>Feb. 5 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Evergreen Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Brainerd, Minn.</b>							
24. FUNERAL DIRECTOR'S SIGNATURE <b>ROBERT A. PUMPHREY</b>						ADDRESS <b>Bethesda, Md.</b>		25a. REC'D BY REGISTRAR <b>FEB 14 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hana</b>					

3388

CENTRAL OF MARYLAND

1918

Albany

25 days

Albany

The Central of Maryland, Baltimore & Annapolis, Inc.

John

Caroline

Harvey

22

June 1, 1918

White

Local

Albany

Albany

Correspondence, Albany

Caroline

John

The Central of Maryland

The Central of Maryland, Baltimore & Annapolis, Inc.

John

John



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2107

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

02084

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda Maryland</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>4904 Hampden Lane</b>			d. STREET ADDRESS <b>9010 Old Georgetown Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Ira</b> First <b>E.</b> Middle <b>Keller</b> Last			4. DATE OF DEATH Month <b>2</b> Day <b>3</b> Year <b>19 61</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Cauc</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-1-1885</b>		9. AGE (In years last birthday) <b>75</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <b>Real Estate</b>		11. BIRTHPLACE (State or foreign country) <b>Missouri</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Henry Keller</b>			14. MOTHER'S MAIDEN NAME <b>Mary Burris</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>578-32-5558</b>		17. INFORMANT <b>Wife</b> <b>Margaret T. Keller</b> Address <b>Same as Item #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Conorary Occulsion (Sudden)</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <b>Frank J. Broscham</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>FRANK J. Broscham</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		<b>2-4-61</b>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2-10-61</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Monocacy Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Beallsville, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>ROBERT A. PUMPHREY</b>		ADDRESS <b>Bethesda, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 8 '61</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate within the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the County Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

# MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2103

<p>1. NAME OF DECEASED [REDACTED]</p>		<p>2. SEX Male</p>	
<p>3. AGE [REDACTED]</p>		<p>4. DATE OF DEATH [REDACTED]</p>	
<p>5. PLACE OF DEATH [REDACTED]</p>		<p>6. OCCASION OF DEATH [REDACTED]</p>	
<p>7. CAUSE OF DEATH [REDACTED]</p>		<p>8. MANNER OF DEATH [REDACTED]</p>	
<p>9. SIGNATURE OF EXAMINER [REDACTED]</p>		<p>10. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>11. SIGNATURE OF DECEASED [REDACTED]</p>		<p>12. SIGNATURE OF NEXT OF KIN [REDACTED]</p>	
<p>13. SIGNATURE OF CLERK [REDACTED]</p>		<p>14. SIGNATURE OF JURY [REDACTED]</p>	
<p>15. SIGNATURE OF JURY [REDACTED]</p>		<p>16. SIGNATURE OF JURY [REDACTED]</p>	
<p>17. SIGNATURE OF JURY [REDACTED]</p>		<p>18. SIGNATURE OF JURY [REDACTED]</p>	
<p>19. SIGNATURE OF JURY [REDACTED]</p>		<p>20. SIGNATURE OF JURY [REDACTED]</p>	
<p>21. SIGNATURE OF JURY [REDACTED]</p>		<p>22. SIGNATURE OF JURY [REDACTED]</p>	
<p>23. SIGNATURE OF JURY [REDACTED]</p>		<p>24. SIGNATURE OF JURY [REDACTED]</p>	
<p>25. SIGNATURE OF JURY [REDACTED]</p>		<p>26. SIGNATURE OF JURY [REDACTED]</p>	
<p>27. SIGNATURE OF JURY [REDACTED]</p>		<p>28. SIGNATURE OF JURY [REDACTED]</p>	
<p>29. SIGNATURE OF JURY [REDACTED]</p>		<p>30. SIGNATURE OF JURY [REDACTED]</p>	
<p>31. SIGNATURE OF JURY [REDACTED]</p>		<p>32. SIGNATURE OF JURY [REDACTED]</p>	
<p>33. SIGNATURE OF JURY [REDACTED]</p>		<p>34. SIGNATURE OF JURY [REDACTED]</p>	
<p>35. SIGNATURE OF JURY [REDACTED]</p>		<p>36. SIGNATURE OF JURY [REDACTED]</p>	
<p>37. SIGNATURE OF JURY [REDACTED]</p>		<p>38. SIGNATURE OF JURY [REDACTED]</p>	
<p>39. SIGNATURE OF JURY [REDACTED]</p>		<p>40. SIGNATURE OF JURY [REDACTED]</p>	
<p>41. SIGNATURE OF JURY [REDACTED]</p>		<p>42. SIGNATURE OF JURY [REDACTED]</p>	
<p>43. SIGNATURE OF JURY [REDACTED]</p>		<p>44. SIGNATURE OF JURY [REDACTED]</p>	
<p>45. SIGNATURE OF JURY [REDACTED]</p>		<p>46. SIGNATURE OF JURY [REDACTED]</p>	
<p>47. SIGNATURE OF JURY [REDACTED]</p>		<p>48. SIGNATURE OF JURY [REDACTED]</p>	
<p>49. SIGNATURE OF JURY [REDACTED]</p>		<p>50. SIGNATURE OF JURY [REDACTED]</p>	
<p>51. SIGNATURE OF JURY [REDACTED]</p>		<p>52. SIGNATURE OF JURY [REDACTED]</p>	
<p>53. SIGNATURE OF JURY [REDACTED]</p>		<p>54. SIGNATURE OF JURY [REDACTED]</p>	
<p>55. SIGNATURE OF JURY [REDACTED]</p>		<p>56. SIGNATURE OF JURY [REDACTED]</p>	
<p>57. SIGNATURE OF JURY [REDACTED]</p>		<p>58. SIGNATURE OF JURY [REDACTED]</p>	
<p>59. SIGNATURE OF JURY [REDACTED]</p>		<p>60. SIGNATURE OF JURY [REDACTED]</p>	
<p>61. SIGNATURE OF JURY [REDACTED]</p>		<p>62. SIGNATURE OF JURY [REDACTED]</p>	
<p>63. SIGNATURE OF JURY [REDACTED]</p>		<p>64. SIGNATURE OF JURY [REDACTED]</p>	
<p>65. SIGNATURE OF JURY [REDACTED]</p>		<p>66. SIGNATURE OF JURY [REDACTED]</p>	
<p>67. SIGNATURE OF JURY [REDACTED]</p>		<p>68. SIGNATURE OF JURY [REDACTED]</p>	
<p>69. SIGNATURE OF JURY [REDACTED]</p>		<p>70. SIGNATURE OF JURY [REDACTED]</p>	
<p>71. SIGNATURE OF JURY [REDACTED]</p>		<p>72. SIGNATURE OF JURY [REDACTED]</p>	
<p>73. SIGNATURE OF JURY [REDACTED]</p>		<p>74. SIGNATURE OF JURY [REDACTED]</p>	
<p>75. SIGNATURE OF JURY [REDACTED]</p>		<p>76. SIGNATURE OF JURY [REDACTED]</p>	
<p>77. SIGNATURE OF JURY [REDACTED]</p>		<p>78. SIGNATURE OF JURY [REDACTED]</p>	
<p>79. SIGNATURE OF JURY [REDACTED]</p>		<p>80. SIGNATURE OF JURY [REDACTED]</p>	
<p>81. SIGNATURE OF JURY [REDACTED]</p>		<p>82. SIGNATURE OF JURY [REDACTED]</p>	
<p>83. SIGNATURE OF JURY [REDACTED]</p>		<p>84. SIGNATURE OF JURY [REDACTED]</p>	
<p>85. SIGNATURE OF JURY [REDACTED]</p>		<p>86. SIGNATURE OF JURY [REDACTED]</p>	
<p>87. SIGNATURE OF JURY [REDACTED]</p>		<p>88. SIGNATURE OF JURY [REDACTED]</p>	
<p>89. SIGNATURE OF JURY [REDACTED]</p>		<p>90. SIGNATURE OF JURY [REDACTED]</p>	
<p>91. SIGNATURE OF JURY [REDACTED]</p>		<p>92. SIGNATURE OF JURY [REDACTED]</p>	
<p>93. SIGNATURE OF JURY [REDACTED]</p>		<p>94. SIGNATURE OF JURY [REDACTED]</p>	
<p>95. SIGNATURE OF JURY [REDACTED]</p>		<p>96. SIGNATURE OF JURY [REDACTED]</p>	
<p>97. SIGNATURE OF JURY [REDACTED]</p>		<p>98. SIGNATURE OF JURY [REDACTED]</p>	
<p>99. SIGNATURE OF JURY [REDACTED]</p>		<p>100. SIGNATURE OF JURY [REDACTED]</p>	

2108

2108

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

02085

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>29 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>	
3. NAME OF DECEASED (Type or print) First <b>Elizabeth</b> Middle <b>E.</b> Last <b>King</b>		4. DATE OF DEATH Month <b>February</b> Day <b>4</b> Year <b>1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 7, 1898</b>
9. AGE (In years last birthday) <b>63 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William E. Clapp</b>		14. MOTHER'S MAIDEN NAME <b>Anna Hudson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>—</b>	
17. INFORMANT (Husband) <b>Alfred M. King</b>		Address <b>As above # 2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Cervix uterine</b> DUE TO (b) <b>171X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from <b>Jan 6</b> 19 <b>61</b> to <b>Feb 4</b> 19 <b>61</b> , that (we) last saw the deceased alive on <b>4 Feb</b> 19 <b>61</b> and that death occurred at <b>M</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>H. C. Magariz</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>H. C. Magariz</b>		22d. ADDRESS <b>809 Viersmire Rd Rockville</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Febr. 7, 1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Prince Georges Co., Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>J. Arthur Edwards</b>		25a. REC'D BY REGISTRAR <b>254 Carroll Wash. D.C.</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>		DATE <b>FEB 8 '61</b>	

2108

STATE OF TEXAS

County of Tarrant

County of Tarrant

State of Texas

(Indemnity)

Alfred J. King

State of Texas

(Indemnity)

Alfred J. King

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

Item 9 Film G281 2-14-61 et

02086

2109

### 1. PLACE OF DEATH

a. COUNTY

Montgomery MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Bethesda

c. LENGTH OF STAY IN 1b

10 days

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Suburban

### 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)

a. STATE

b. COUNTY

Md. Mont. Co.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Chevy Chase

d. STREET ADDRESS

13616-Taylor St.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

### 3. NAME OF DECEASED (Type or print)

First Middle Last Raymond W. King

### 4. DATE OF DEATH

Month Day Year Feb 3 1961

### 5. SEX

male

### 6. COLOR OR RACE

white

### 7. MARRIED

☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

### 8. DATE OF BIRTH

7/15/87

### 9. AGE (In years last birthday)

74

### IF UNDER 1 YEAR

Months Days Hours Min.

### IF UNDER 24 HRS.

Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Investigation (retired)

10b. KIND OF BUSINESS OR INDUSTRY

U.S. Govt.

11. BIRTHPLACE (County & State, or foreign country)

Va.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

### 13. FATHER'S NAME

Adolphus King

### 14. MOTHER'S MAIDEN NAME

Harriet

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)

yes 1907

16. SOCIAL SECURITY NO.

216-40-9615

### 17. INFORMANT

Margaret B. King

Address 3616 Taylor St. Chevy Chase, Md.

### 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

#### PART I. DEATH WAS CAUSED BY:

#### IMMEDIATE CAUSE (a)

420.1 DUE TO

Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.

Myocardial Infarct acute. ant.

Anterio sclerosis.

#### INTERVAL BETWEEN ONSET AND DEATH

9 days.

#### PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)

Rt. hemiplegia, aphasia, Cardiac failure.

#### 19. WAS AUTOPSY PERFORMED?

YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY

Month, Day, Year

Hour e.m. p.m.

19

20d. INJURY OCCURRED

While Not While et work ☐ et work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from 1953, 19, to Feb. 3, 1961, that (I) (we) last saw the deceased alive on February 2, 1961, and that death occurred at 3:30 P.M. from the causes and on the date stated above.

### 22a. SIGNATURE

Irene G. Tamagna

M.D.

### ATTENDING PHYS.

### MED. DIRECTOR

### STAFF PHYS.

### 22b. DATE SIGNED

2/3/61

### 22c. PHYSICIAN'S NAME (Type)

IRENE G. TAMAGNA M.D.

### 22d. ADDRESS

7101 Conn. Ave Chevy Chase 15, Md.

### 23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

### 23b. DATE THEREOF

2/7/61

### 23c. NAME OF CEMETERY OR CREMATORY

Parklawn Cemetery

### 23d. LOCATION (City, town or county)

Rockville, Maryland

(State)

### 24 FUNERAL DIRECTOR'S SIGNATURE

Robert A. Pumphrey

### ADDRESS

Bethesda, Maryland

### 25a. REC'D BY REGISTRAR

DATE FEB 8 '61

### 25b. REGISTRAR'S SIGNATURE

Arthur S. Kraus

TO HOSPITAL OR FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

1942



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **02087**

**2110**

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>D. C.</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN lb <b>2 hrs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>		4 7 X-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>4932 Bethesda Avenue</b>				d. STREET ADDRESS <b>3760-39th St. N. W.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Robert</b> Middle <b>Newell</b> Last <b>Kinnaird</b>				4. DATE OF DEATH Month <b>February</b> Day <b>21</b> Year <b>19 61</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/27/1884</b>	9. AGE (In years last birthday) <b>76</b> yrs.	IF UNDER 1 YEAR Months <b>5</b> Days <b>28</b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Civil Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Army</b>		11. BIRTHPLACE (State or foreign country) <b>Indiana</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Robert Kinnaird</b>				14. MOTHER'S MAIDEN NAME <b>Emma Newell</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>434-44-8507</b>		17. INFORMANT <b>Virginia Kinnaird-cousin</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO <b>420.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b></b> DUE TO <b></b> (c) <b></b>						INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b></b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Frank J. Broschart</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		22b. DATE THEREOF <b>2/25/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>		22d. LOCATION (City, town, or county) (State) <b>Suitland, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>				ADDRESS <b>Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 24 '61</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hays</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the date of death and the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



1  
TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
2111  
CERTIFICATE OF DEATH  
02088

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived: If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg R.F.D. #2</u>				c. LENGTH OF STAY IN 1b <u>2 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Highland, Md</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Ammons Nursing Home</u>				d. STREET ADDRESS <u>12X-2</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Henry</u> Middle <u>James</u> Last <u>Kosh</u>				4. DATE OF DEATH Month <u>February</u> Day <u>14</u> Year <u>1961</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>CO1</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 14, 1868</u>			
9. AGE (In years lost birthday) <u>92</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer.</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>									
13. FATHER'S NAME <u>James Kosh</u>				14. MOTHER'S MAIDEN NAME <u>Rebecca</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>  </u>				16. SOCIAL SECURITY NO. <u>  </u>		17. INFORMANT <u>Nursing Home Records</u> Address <u>  </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myocarditis.</u> <u>4-2-2-1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Senility.</u> DUE TO (c) <u>Generalized Arteriosclerosis.</u>								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> o. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>				20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from <u>1959</u> , 19 <u>  </u> to <u>2/14</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>2/14</u> , 19 <u>61</u> , and that death occurred at <u>  </u> M, from the causes and on the date stated above.									
22a. SIGNATURE <u>Luciano P. Leal</u>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>2/17/61</u>			
22c. PHYSICIAN'S NAME (Type) <u>Luciano P. Leal</u>				22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>2/18/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ash Memorial Cemetery</u>			
23d. LOCATION (City, town, or county) (State) <u>Sandy Springs Md</u>									
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert J. Brander</u>				25a. REC'D BY REGISTRAR <u>Arthur S. Thomas</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>			
DATE <u>FEB 24 '61</u>									

Generalized Anterior  
Lateral Sclerosis  
Chronic Myelopathy

1922 2112 13

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1922 2112 13

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CERTIFICATE OF DEATH

Reg. Dist. No.

02089

1. PLACE OF DEATH a. COUNTY <b>Montg</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montg</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Germantown</b>				c. LENGTH OF STAY IN 1b <b>20 yrs</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Martha</b> Middle <b>Ann</b> Last <b>Laforce</b>				4. DATE OF DEATH Month <b>Feb</b> Day <b>20</b> Year <b>19 61</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 19-1883</b>	
9. AGE (In years last birthday) <b>77 yrs.</b>		10. IF UNDER 1 YEAR Months <b>9</b> Days <b>1</b> Hours <b></b> Min. <b></b>		11. IF UNDER 24 HRS. Hours <b></b> Min. <b></b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Home Work</b>		11. BIRTHPLACE (State or foreign country) <b>Kentucky</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>							
13. FATHER'S NAME <b>William Smith</b>				14. MOTHER'S MAIDEN NAME <b>Darcus Embury</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>(If yes, give war or dates of service)</b>				16. SOCIAL SECURITY NO. <b>INFORMANT</b> <b>John L. Laforce. Germantown. Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>February 28, 1956</b> to <b>February 20, 1961</b> , that I last saw the deceased alive on <b>February 18, 1961</b> , and that death occurred at <b>Md.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>26618 Ridge Road</b> DATE SIGNED ACTUAL SIGNATURE <b>James P. Kerr</b> M.D. <b>26618 Ridge Road</b> PHYSICIAN'S NAME (Type) <b>James P. Kerr M.D.</b> <b>Damascus, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>2-23-61</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>Germantown Baptist Ch.</b>				22d. LOCATION (City, town, or county) (State) <b>Germantown Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ernest C. Gartner. Gaithersburg. Md.</b>				24a. REC'D BY REGISTRAR <b>DATE FEB 23 '61</b>			
24b. REGISTRAR'S SIGNATURE <b>Arthur S. House</b>							

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02090

1. PLACE OF DEATH e. COUNTY <b>Montgomery</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>	
c. LENGTH OF STAY IN 1b <b>D.O.A</b>		d. STREET ADDRESS <b>4012 Everett St.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Suburban</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Eleanor Anne Lawrence</b>		4. DATE OF DEATH Month <b>Feb.</b> Day <b>3</b> Year <b>19 61</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/18/32</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Historian N.I.H</b>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>28</b> yrs.
11. BIRTHPLACE (State or foreign country) <b>Mass</b>		12. CITIZEN OF WHAT COUNTRY? <b>21-56</b>	
13. FATHER'S NAME <b>Albert F. Lawrence</b>		14. MOTHER'S MAIDEN NAME <b>Gladys H. Morrill</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>A.S. Lawrence Jr</b>		Address <b>Stim 2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Exsanguination</b> DUE TO (b) <b>Rupture, Internal Carotid Arteries</b> DUE TO (c) <b>Gunshot Wound, Head</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b> <b>Sudden</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <b>Shot in head by person unknown</b>	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>Feb. 3 19 61</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Conn. Ave. Kensington Monty Md</b>	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Frank J. Brochart</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Frank J. Brochart</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-transit 2-6-61</b>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <b>Forest Hill Cem.</b>		22d. LOCATION (City, town, or country) (State) <b>Fitchburg, Mass.</b>	
23. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY</b>		ADDRESS <b>Bethesda, Md.</b>	
24a. REC'D BY REGISTRAR <b>FEB 8 61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Frank</b>	

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Washington D.C.

4012 Everett St.

Elaborate and elaborate

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Robert L. ...

Robert L. ...

Robert L. ...

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, it should be executed by the funeral director. Pages 4 and 5 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

02091

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. LENGTH OF STAY IN 1b <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>D.C.</b>		b. COUNTY <b>Washington</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>U.S. Naval Ordinance Laboratory</b>						d. STREET ADDRESS <b>6614 7th Place, N.W.</b>			
3. NAME OF DECEASED (Type or print) <b>William</b>		First <b>Filmore</b>		Middle <b>Lewis</b>		Last		4. DATE OF DEATH Month <b>Feb. 4</b>	
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH <b>5/11/1901</b>		9. AGE (In years last birthday) <b>59</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>machanic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>refrigeration</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>William F. Lewis</b>						14. MOTHER'S MAIDEN NAME <b>Olive May Watkins</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW # 2 578-03-7177</b>		17. INFORMANT <b>U.S. Naval Ord. record</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Carbon dioxide poisoning</b> DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <b>Refrigeration system dumped &amp; released Carbon dioxide gas.</b>							
20c. TIME OF INJURY Month, Day, Year <b>4:55 p.m. 2/4/ 19 61</b>		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>laboratory</b>		20f. (City or town) <b>Silver Spring, Montg.</b>		(County) (State) <b>Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>									
ACTUAL SIGNATURE <b>Frank J. Broschart</b>		EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED <b>2/4/61</b>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 7, 1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Bethesda Meth.</b>		22d. LOCATION (City, town, or country) (State) <b>Browningsville, Md.</b>			
23. FUNERAL DIRECTOR <b>Chin L. Moleworth</b>		ADDRESS <b>Damascus, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 9 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Knecht</b>			

MEDICAL CERTIFICATION

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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Name of Deceased: [illegible]  
Age: [illegible]  
Sex: [illegible]  
Date of Birth: [illegible]  
Place of Birth: [illegible]  
U.S. Nat. Lab. [illegible]

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Date of Death: [illegible]  
Time of Death: [illegible]  
Place of Death: [illegible]

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Cause of Death: [illegible]  
Manner of Death: [illegible]  
Signature of Medical Examiner: [illegible]

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Signature of Coroner: [illegible]  
U.S. Nat. Lab. [illegible]  
Date: [illegible]

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Signature of Medical Examiner: [illegible]  
U.S. Nat. Lab. [illegible]  
Date: [illegible]

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Signature of Coroner: [illegible]  
U.S. Nat. Lab. [illegible]  
Date: [illegible]

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Signature of Medical Examiner: [illegible]  
U.S. Nat. Lab. [illegible]  
Date: [illegible]

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Signature of Coroner: [illegible]  
U.S. Nat. Lab. [illegible]  
Date: [illegible]

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Signature of Medical Examiner: [illegible]  
U.S. Nat. Lab. [illegible]  
Date: [illegible]

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

02092

1. PLACE OF DEATH a. COUNTY <u>Montgomery County</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>59 Bethesda</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6700 Bradley Boulevard</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Minnie</u> Middle <u>(none)</u> Last <u>Low</u>			4. DATE OF DEATH Month <u>Feb.</u> Day <u>7</u> Year <u>1961</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 22, 1876</u>		9. AGE (In years last birthday) yrs. <u>84</u>	IF UNDER 1 YEAR Months <u>6</u> Days <u>13</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>John E. Low</u>				14. MOTHER'S MAIDEN NAME <u>Emma V. Heiberger</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Kenneth Kelly-Nephew-same 2d</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertension</u> DUE TO (c) <u>Far Advanced Arteriosclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs.</u> <u>8 years</u> <u>8 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1951</u> to <u>1951</u> , that (I) (we) last saw the deceased alive on <u>2/2</u> 19 <u>61</u> , and that death occurred at <u>2:15</u> PM, from the causes and on the date stated above.							
22a. SIGNATURE <u>Frank Y. Jagers Jr.</u> M.D.			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>2/7/61</u>		
22c. PHYSICIAN'S NAME (Type) <u>FRANK Y. Jagers Jr.</u>			22d. ADDRESS <u>5707 Wisconsin Ave. Chevy Chase Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/9/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Congressional Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 14 '61</u>	
				25b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

2115

Occurrence

1000 Broadway, New York

(Date)

Place

July 22, 1914

Time

10:00 AM

Place

Time

Dr. J. H. H. H.

Dr. J. H. H. H.

Dr. J. H. H. H.

Dr. J. H. H. H.

Dr. J. H. H. H.

*[Faint, illegible text, likely bleed-through from the reverse side of the page]*



**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

02093

1. PLACE OF DEATH COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
MONTGOMERY		PRINCE GEORGE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
TAKOMA PARK		TAKOMA PARK	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
WASHINGTON SANITARY HOSP. 7600 CARROLL AVE.		309 ELM AVENUE	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
First Middle Last		Month Day Year	
SAMUEL KNOX MACATEE		FEBRUARY 4 1961	
5. SEX		6. COLOR OR RACE	
MALE		WHITE	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	
		1-18-00	
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS.	
61		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
MACHINIST		DANCE	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
SCOTLAND		SCOTLAND	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
JOHN BOYD		ISABELLA ARMSTRONG	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
NO		578-09-9307	
17. INFORMANT		Address	
HOSPITAL RECORDS - WASH. SANITARY HOSP. T.P. MD			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCT 420-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO ATHEROSCLEROSIS OF CORONARY ARTERIES (c) GENERALIZED ARTERIOSCLEROSIS		3 min. 6 yrs. 20 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2-11-61 to 2-14-61, that (I) (we) last saw the deceased alive on 2-12-61, and that death occurred at 10 PM, from the causes and on the date stated above.			
22a. SIGNATURE		22b. DATE SIGNED	
Charles T. Carroll			
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
Charles T. Carroll, M.D.		6801 6th St. N.W. Wash. 12 D.C.	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	
Burial		Feb. 8, 1961	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
Fort Lincoln Cemetery		Prince George County, Md	
24. FUNERAL DIRECTOR'S SIGNATURE		25. REC'D BY REGISTRAR	
Arthur Walters		DATE FEB 8 '61	
25a. ADDRESS		25b. REGISTRAR'S SIGNATURE	
254 Carroll St. N.W. DC		Arthur S. Kline	

3118

13 110 214

13 214

Handwritten text

02094

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

1917

State of New York

County of ...

City of ...

Residence

Occupation

Illness

Signature

Witness

Signature

Signature

Signature

Signature

Signature

Signature

Signature

Signature

Signature

Signature

Signature

2/10/17

In my presence and in the presence of the witnesses

Signature

TO HOSPITAL OR FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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15M 9/60

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
2118											
02095											
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>2925 Terrace Dr.</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b> d. STREET ADDRESS <b>2925 Terrace Dr.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>JOHN</b>						4. DATE OF DEATH <b>February 13th, 1961</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 24, 1887</b>		9. AGE (In years last birthday) <b>73</b>		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Merchant</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Italy</b>			12. CITIZEN OF WHAT COUNTRY <b>U.S.</b>		
13. FATHER'S NAME <b>John B. Mandara</b>						14. MOTHER'S MAIDEN NAME <b>Antonetta Ziccardi</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. (If giver or dates of service)		17. INFORMANT <b>Angelina Mandara same as above</b> Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> DUE TO (b) <b>Rheumatic Heart, Mitral &amp; Aortic stenosis</b> DUE TO (c) <b>4/10X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)										INTERVAL BETWEEN ONSET AND DEATH <b>3</b> <b>40 yrs +</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour e.m. p.m.		Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>Feb 11</b> , 19 <b>60</b> to <b>Feb 13</b> , 19 <b>61</b> , that (I) ( <del>was</del> ) last saw the deceased alive on <b>Feb 13</b> , 19 <b>61</b> , and that death occurred at <b>5:35 PM</b> , from the causes and on the date stated above.											
22a. SIGNATURE <b>J. D. Damian</b> 22c. PHYSICIAN'S NAME (Type) <b>Dr. J. D. Damian</b>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City, town or county) (State)			
<b>BURIAL</b>		<b>2-17-61</b>		<b>Fort Lincoln</b>				<b>Bladensburg, Md.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Lee Funeral Home - Washington D.C.</b>						ADDRESS		25a. REC'D BY REGISTRAR <b>FEB 16 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

see Internal memo - Washington D.C.

Special Agent in Charge - Baltimore

Baltimore, Md.

Dear Sir:

Reference is made to your letter of January 13, 1961, regarding the above captioned matter.

Angela Barbara Jones as above

Angela Barbara Jones

Refined

Male

X

June 24, 1987

73

Ms ndars

February 13, 1961

2925 Terrace Dr.

2925 Terrace Dr.

Grey Chase

Grey Chase

Montgomery

Montgomery

2112

2112



**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

02096

1. PLACE OF DEATH a. COUNTY <b>2119 Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Arlington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>				c. LENGTH OF STAY IN 1b <b>29 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>				d. STREET ADDRESS <b>5116 N. 37th Street</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Sarah</b> Middle <b>Gilbert</b> Last <b>MARQUARDT</b>		4. DATE OF DEATH Month <b>February</b> Day <b>10</b> Year <b>1961</b>					
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-23-24</b>	9. AGE (In years last birthday) <b>36</b> yrs.	IF UNDER 1 YEAR Months <b>36</b> Days <b>36</b> Hours <b>36</b> Min.	IF UNDER 24 HRS. Hours <b>36</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>- - - - -</b>		11. BIRTHPLACE (State or foreign country) <b>Massachusetts</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Edwin C. GILBERT</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth CORBETT</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>(H) Capt. R. C. Marquardt, USN, same as #2</b>		17. INFORMANT <b>(H) Capt. R. C. Marquardt, USN, same as #2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma Breast c Metastases</b> DUE TO <b>170X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO				INTERVAL BETWEEN ONSET AND DEATH <b>4 yrs.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <b>(H)</b> (this hospital) attended the deceased from <b>Jan. 12</b> 19 <b>61</b> to <b>Feb. 10</b> 19 <b>61</b> , that <b>(H)</b> (we) last saw the deceased alive on <b>Feb. 10</b> 19 <b>61</b> , and that death occurred at <b>1:40PM</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <i>W. B. Hooper</i>				22b. DATE SIGNED <b>2-10-61</b>		22c. PHYSICIAN'S NAME (Type) <b>W. B. HOOVER, LT, MC, USN</b>	
22d. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE THEREOF <b>2-14-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>		23d. LOCATION (City, town, or county) (State) <b>Suitland Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Jos. Gawler's Sons</i>				25a. REC'D BY REGISTRAR <b>5 FEB 14 '61</b>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. House</i>	
25c. ADDRESS <b>Jos. Gawler's Sons, 1756 Penn. Ave., NW, WashDC</b>							

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

• 2007 •

1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

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**Abstract**

**CERTIFICATE OF DEATH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2120

02097

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Mont.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> 48			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				d. STREET ADDRESS <u>4911 Hampden Lane</u>			
3. NAME OF DECEASED (Type or print) First <u>Wataro</u> Middle <u>Matsuka</u> Last <u>Matsuka</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>21</u> Year <u>1961</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>yellow</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 29, 1880</u>	
9. AGE (In years lost birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Fisherman</u>		11. BIRTHPLACE (State or foreign country) <u>Japan</u>	
12. CITIZEN OF WHAT COUNTRY? <u>Japan</u>							
13. FATHER'S NAME <u>Hisaji Matsuka</u>				14. MOTHER'S MAIDEN NAME <u>Matsuka</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>339-24-8568</u>			
17. INFORMANT <u>Ichiro Matsouka, Son-Chicago, Ill.</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cachexia, malnutrition.</u> <u>157X</u> DUE TO <u>prolonged vomiting &amp; intestinal obstruction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of head of pancreas -</u> DUE TO <u>4-5 yrs.</u> (c) <u>Hypotension, Electrolyte loss</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>o. m.</u> <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>2-21-1961</u> to <u>2-21-1961</u> , that (I) <u>last</u> saw the deceased alive on <u>2-21-1961</u> , and that death occurred at <u>8:22 A.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Linwood H. Johnson Jr.</u>				22b. DATE SIGNED <u>2-22-61</u>			
22c. PHYSICIAN'S NAME (Type) <u>Linwood H. Johnson Jr.</u>				22d. ADDRESS <u>4630 Montgomery Ave, Bethesda, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>2/26/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		23d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Humphrey</u>				25a. REC'D BY REGISTRAR <u>FEB 24 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	
ADDRESS <u>Bethesda, Maryland</u>							

Coroner notified and will approve.

8150

CERTIFICATE OF DEATH

IN THE CITY OF NEW YORK  
COUNTY OF NEW YORK

Deceased

Married

Reported

1950-01-01 to 1950-01-01

Deceased

Married

Reported

1950-01-01 to 1950-01-01

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

**ENDING PHYSICIAN:** The law requires that the death certificate be executed            in 24            after death. Page 4 may            obtained by the hospital or attending physician.

**FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

1. PLACE OF DEATH e. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Lakewood Park</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hypsville</u>	
c. LENGTH OF STAY in lb <u>5 days</u>		d. STREET ADDRESS <u>2526 Avalon Pl.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington San &amp; Hosp</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Henry</u> Middle <u>(Wm)</u> Last <u>Matthews</u>		4. DATE OF DEATH Month <u>2</u> Day <u>10</u> Year <u>1961</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-15-14</u>
9. AGE (in years last birthday) <u>46 yrs.</u>		10. IF UNDER 1 YEAR Months <u>46</u> Days <u>0</u>	
11. IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Welder</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hustine Chevy</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
13. FATHER'S NAME <u>Edward Matthews</u>		14. MOTHER'S MAIDEN NAME <u>Molly Dockman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>yes w.w.i.</u>		16. SOCIAL SECURITY NO. <u>058-01-3403</u>	
17. INFORMANT <u>p &amp; Hosp Record.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE MYOCARDIAL INFARCTION</u> DUE TO (b) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u> DUE TO (c) <u>420-1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>PREVIOUS MYOCARDIAL INFARCTION 4 MONTHS AGO</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>420-1</u>	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State) <u>10</u>
21. I certify that (I) (this hospital) attended the deceased from <u>OCTOBER, 1955</u> to <u>FEBRUARY, 1961</u> , that (I) (we) last saw the deceased alive on <u>FEBRUARY 10, 1961</u> , and that death occurred at <u>7:02 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Robert L. Krichmar</u> M.D.		22b. DATE SIGNED <u>FEBRUARY 10 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>ROBERT L. KRICHMAR</u>		22d. ADDRESS <u>7733 ALASKA AVE N.W. WASH 12 D.C.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>FEB-12-1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>NAT'L MEM. PARK</u>	23d. LOCATION (City, town or county) (State) <u>FALLS CHURCH, VA.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Joe Clayton</u>		25a. REC'D BY REGISTRAR <u>FEB 14 '61</u>	
ADDRESS <u>4217 9th ST. S.W.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Knease</u>	

1915

①

Acute myocardial infarction  
Posterior wall infarction  
Previous myocardial infarction + angina

October 12, 1915

February 10, 1916

Robert A. Archibald  
7133 Avenue A, New York City

Robert A. Archibald  
7133 Avenue A, New York City



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
2122  
CERTIFICATE OF DEATH

02099

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Georgia</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kennesaw</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>		d. STREET ADDRESS <b>Box 417</b>	
3. NAME OF DECEASED (Type or print) First <b>Flora</b> Middle <b>Nell</b> Last <b>MAYSON</b>		4. DATE OF DEATH Month <b>February</b> Day <b>11</b> Year <b>19 61</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-15-22</b>
9. AGE (In years lost birthday) <b>39</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY - - - - -	
11. BIRTHPLACE (State or foreign country) <b>Georgia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Joe BENFIEL</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT <b>(H) Efford MAYSON CS2 USN, Same as #2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> 433.0 DUE TO <b>Instantaneous</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cause Unknown</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <b>he</b> (this hospital) attended the deceased from <b>Feb. 1</b> 19 <b>61</b> to <b>Feb. 11</b> 19 <b>61</b> , that <b>he</b> (we) last saw the deceased alive on <b>Feb. 11</b> 19 <b>61</b> , and that death occurred at <b>7:20 PM</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>William P. Baker</b>		22b. DATE SIGNED <b>2-12-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>William P. BAKER, LT, MC, USN</b>		22d. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-Shipment 2-13-61</b>		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY <b>Level Grove Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Cornelia Georgia</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Tyson Wheeler</b>		25a. REC'D BY REGISTRAR <b>FEB 14 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>		25c. ADDRESS <b>Rockville, Md.</b>	

2182

STATE OF DEATH

300-1

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300-1

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any deaths are necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02100

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Takoma Park		b. COUNTY Montgomery	
c. LENGTH OF STAY in 1b 70 Days		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Wheaton Md. 34	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington Sanitarium		d. STREET ADDRESS 12704 Holdridge Rd.	
3. NAME OF DECEASED (Type or print) Lelia Bernice McAllister		4. DATE OF DEATH 2 15 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-14-18
9. AGE (In years last birthday) 42 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	11. BIRTHPLACE (State or foreign country) Minnesota
12. CITIZEN OF WHAT COUNTRY? American		13. FATHER'S NAME Earl Shuey	
14. MOTHER'S MAIDEN NAME Lelia Shuey		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) NO	
16. SOCIAL SECURITY NO. 185-05-5485		17. INFORMANT Mrs Lucille Bryan Apt. 301 Wash DC.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ASPHIXIA DUE TO BRONCHIAL SECRETIONS DUE TO (b) PARTIAL RESPIRATORY PARALYSIS DUE TO (c) DEGENERATION OF SPINAL CORD DUE TO GUNSHOT WOUND PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot self in lower neck with revolver 20c. TIME OF INJURY Month, Day, Year 4:37 p.m. 12-7 1960 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home 20f. (City or town) (County) (State) Wheaton monty md		INTERVAL BETWEEN ONSET AND DEATH 3 DAYS 9 WEEKS 9 WEEKS	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) 2-15-61	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2/17/61	
22c. NAME OF CEMETERY OR CREMATORY PARKLAWN CEMETERY		22d. LOCATION (City, town, or country) (State) MONTGOMERY COUNTY, MARYLAND	
23. FUNERAL DIRECTOR Raymond E. Pumphrey, Inc. Raymond A. Ziska		24a. REC'D BY REGISTRAR DATE FEB 20 '61	
24b. REGISTRAR'S SIGNATURE Arthur S. Kears			

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Page 4 after death  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
may be received by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

2124

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

02101

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>South Carolina</b> b. COUNTY <b>Greenville</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>13 Days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Karen</b> Middle <b>Elizabeth</b> Last <b>McCall</b>		4. DATE OF DEATH Month <b>February</b> Day <b>4</b> Year <b>1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 15, 1955</b>
9. AGE (In years last birthday) <b>5</b> yrs.		IF UNDER 1 YEAR Months <b>5</b> Days <b>7</b> Hours <b>7</b> Min. <b>3</b>	IF UNDER 24 HRS. Hours <b>7</b> Min. <b>3</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Child</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	11. BIRTHPLACE (State or foreign country) <b>South Carolina</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Alvin McCall Jr.</b>	
14. MOTHER'S MAIDEN NAME <b>Wanda Ervin</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>	
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>The Medical Records</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>289.2</b> IMMEDIATE CAUSE (a) <b>Cardiac Arrhythmia or Arrest</b> DUE TO (b) <b>Hyperkalemia</b> DUE TO (c) <b>Cystinosis with Renal Involvement</b> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b> <b>months</b> <b>5 yrs 10 mos.</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>January 22, 1961</b> , to <b>February 4, 1961</b> , that (I) (we) last saw the deceased alive on <b>February 4, 1961</b> , and that death occurred at <b>4:45 AM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Dr. Daniel V. Kimberg</b>		22b. DATE SIGNED <b>Feb 4, 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>Daniel V. Kimberg M.D.</b>		22d. ADDRESS <b>The Clinical Center National Institutes Of Health Bethesda 14, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-transit 2-4-61</b>		23b. DATE THEREOF <b>2-4-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Mem. Park</b>		23d. LOCATION (City, town, or county) (State) <b>Greenville, South Car.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>ROBERT A. PUMPHREY</b>		25a. REC'D BY REGISTRAR <b>Feb 8 '61</b>	
ADDRESS <b>Bethesda, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. House</b>	

15184

South Carolina

Greenville

100 Postmont Road

Mobile Alabama

April 12, 1952

South Carolina

Walter Smith

The National Bureau

The National Bureau, Department of Justice

Washington, D. C.

Dear Sir:

Reference is made to your letter of January 22, 1952.

Very truly yours,

Very truly yours,  
Special Agent in Charge

Enclosed for the National Bureau are two copies of a letterhead memorandum dated and captioned as above.

Respectfully,  
Special Agent in Charge

Very truly yours,  
Special Agent in Charge

Very truly yours,  
Special Agent in Charge



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any deaths are necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

2125  
MONTGOMERY STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>md</u> b. COUNTY <u>montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>			
c. LENGTH OF STAY IN 1b <u>6 yrs</u>				d. STREET ADDRESS <u>1601 Broadwood Dr</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>601 Broadwood Dr</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Russell Rutland McGuire</u>				4. DATE OF DEATH Month <u>Feb</u> Day <u>19</u> Year <u>1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-16-06</u>	
9. AGE (In years last birthday) <u>54</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Public relations</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov.</u>		11. BIRTHPLACE (State or foreign country) <u>La</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>							
13. FATHER'S NAME <u>Marion H. McGuire</u>				14. MOTHER'S MAIDEN NAME <u>Walter</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>WW 2</u>				16. SOCIAL SECURITY NO. <u>577-26-3808</u>			
17. INFORMANT <u>Grace McGuire (wife)</u>				Address <u>Lin 2</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cornary occlusion</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (b) <u>  </u> (a), stating the underlying cause last. (c) <u>  </u> DUE TO <u>  </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) (County) (State) <u>  </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <u>2-19-61</u>			
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>							
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
Address (Street, city, town, or county) <u>  </u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur-Transit</u>		22b. DATE THEREOF <u>2/22/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Metairie</u>		22d. LOCATION (City, town, or country) (State) <u>New Orleans, La.</u>	
23. FUNERAL DIRECTOR Tyson Wheeler Funeral Home 1331 E. Montg. Ave., Rockville, Md.				24a. REC'D BY REGISTRAR DATE <u>FEB 23 '61</u>			
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

MEDICAL CERTIFICATION

2152

NO. 2152  
MAY 1912



State of Massachusetts, County of Suffolk, City of Boston.  
I, the undersigned, being a duly qualified Medical Examiner, do hereby certify that on the 1st day of May, 1912, at the City of Boston, in the County of Suffolk, State of Massachusetts, I examined the body of  
[Name of Deceased]  
who died at the residence of [Address]  
and found that the cause of death was [Cause of Death]  
and that the death was due to [Cause of Death]  
and that the death was not due to any other cause.  
Witness my hand and the seal of the Department of Health at the City of Boston, this 1st day of May, 1912.

RECEIVED MAY 1 1912

3 1 -  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any death is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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2

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
2126 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 02103											
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>West Chevy Chase</b>						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>West Chevy Chase</b>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>4901 Crescent Street</b>						d. STREET ADDRESS <b>4901 Crescent Street</b>					
3. NAME OF DECEASED (Type or print) <b>Robert Taylor McMullen</b>						4. DATE OF DEATH <b>February 13 19 61</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8/5/1871</b>		9. AGE (in years last birthday) <b>89</b> yrs.		10. IF UNDER 1 YEAR <b>6</b> Months <b>8</b> Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Carpenter</b>				11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Levi McMullen</b>						14. MOTHER'S MAIDEN NAME <b>Cansada Taylor</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give year or dates of service)						16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Edith V. Robey-daughter-same 2d</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c) DUE TO										INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>Frank J. Broschart</b> M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED <b>2/13/61</b>		
EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>						22b. DATE THEREOF <b>2/15/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Nat. Memorial Park</b>		22d. LOCATION (City, town, or country) (State) <b>Falls Church, Virginia</b>	
23. FUNERAL DIRECTOR <b>Robert A. Pumphrey</b>						ADDRESS <b>Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR <b>FEB 15 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraw</b>	

3515

## CERTIFICATE OF DEATH

Reg. Dist. No. 02104

2127

1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>COLTSVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING MD</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MARLEA NURSING HOME</u>		d. STREET ADDRESS <u>948 NORTHAMPTON DR</u>	
3. NAME OF DECEASED (Type or print) First <u>Louise</u> Middle <u>A.</u> Last <u>MELIA</u>		4. DATE OF DEATH Month <u>2</u> Day <u>12</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 3, 1898</u>
9. AGE (In years last birthday) <u>62</u> yrs.		IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Telephone Co</u>	
11. BIRTHPLACE (State or foreign country) <u>WASH. DC</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CHARLES SANFORD</u>		14. MOTHER'S MAIDEN NAME <u>ANNIE WALSH</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>578-07-0302</u>	
17. INFORMANT <u>FRANCIS A MELIA - ABOVE</u>		Address <u>  </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>332x cerebral infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>cerebral thrombosis</u> DUE TO (c) <u>cerebral arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs</u> <u>12 hrs</u> <u>@ 5 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Leukitis &amp; coronary arteriosclerosis</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 <u>  </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>12/11/1961</u> to <u>2/12/1961</u> , that I last saw the deceased alive on <u>2/12/1961</u> , and that death occurred at <u>8:00 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Stephen N. Jones</u> M.D.		ADDRESS (Street, city or town, state) <u>Rockville, Md</u>	
DATE SIGNED <u>2/12/61</u>		PHYSICIAN'S NAME (Type) <u>STEPHEN N. JONES</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>FEB-14-1961</u>	22c. NAME OF CEMETERY OR CREMATORY <u>GATE OF HEAVEN</u>	22d. LOCATION (City, town, or county) (State) <u>WHEATON MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Taltavell</u>		ADDRESS <u>3603 14th St NW WASH DC</u>	
24a. REC'D BY REGISTRAR <u>1461</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. It is to be filed with the vital records office of the State Department of Health. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
2128 CERTIFICATE OF DEATH

02105

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>2 1/2 hours</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>55 Chevy Chase,</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Suburban</b>				d. STREET ADDRESS <b>1 4610 Davidson Drive</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Joseph</b> First <b>Meyrson</b> Middle <b>Meyrson</b> Last		4. DATE OF DEATH <b>Feb. 27 19 61</b>		Month <b>27</b> Day <b>19</b> Year <b>61</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2/16/86</b>	
9. AGE (In years last birthday) <b>75 yrs.</b>		IF UNDER 1 YEAR Months <b>75</b> Days <b>75</b> Hours <b>75</b> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Stock Broker</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>New York</b>		13. FATHER'S NAME <b>Nathan Meyrson</b>		14. MOTHER'S MAIDEN NAME <b>Minnie - - -</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>- - - - -</b>		17. INFORMANT <b>Martha V. (wife)</b>		Address <b>same as above</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <b>200.2</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) <b>gastrointestinal hemorrhage from malignant lymphoma</b>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 11, 1961</b> to <b>Feb 27, 1961</b> , that (I) <del>(was)</del> last saw the deceased alive on <b>Feb 27, 1961</b> , and that death occurred at <b>9:30 A.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Dr Joseph Kenrick</b>		M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>2/27/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>DR JOSEPH KENRICK</b>		22d. ADDRESS <b>6450 Wisconsin Ave, Bethesda, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3-2-1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Suitland, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph Souleir Sons</b>		ADDRESS <b>1750 Penn Ave</b>		25a. REC'D BY REGISTRAR <b>MAR 1 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

5137

1. Name of person to whom the property is being transferred  
 2. Name of person from whom the property is being transferred  
 3. Description of the property  
 4. Date of transfer  
 5. Signature of person to whom the property is being transferred  
 6. Signature of person from whom the property is being transferred  
 7. Name of the person who is the owner of the property  
 8. Address of the person who is the owner of the property  
 9. City and State of the person who is the owner of the property  
 10. Country of the person who is the owner of the property

*Particulars of property for subject of file*

1. Name of person to whom the property is being transferred  
 2. Name of person from whom the property is being transferred  
 3. Description of the property  
 4. Date of transfer  
 5. Signature of person to whom the property is being transferred  
 6. Signature of person from whom the property is being transferred  
 7. Name of the person who is the owner of the property  
 8. Address of the person who is the owner of the property  
 9. City and State of the person who is the owner of the property  
 10. Country of the person who is the owner of the property

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

2129

02106

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>			
c. LENGTH OF STAY IN 1b <u>2 yrs. 2 mo.</u>				d. STREET ADDRESS <u>3542 Raymoor Rd.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Congressional Manor San.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>V.</u> Last <u>Michael</u>				4. DATE OF DEATH Month <u>February</u> Day <u>18</u> Year <u>19 61</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5/21/65</u>	
9. AGE (In years lost birthday) <u>95</u> yrs.		IF UNDER 1 YEAR Months <u>8</u> Days <u>27</u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>George Lithgow</u>				14. MOTHER'S MAIDEN NAME <u>Florence J. Pettigrew</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. Brotherhood-daughter-same 2d</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>491X Brochopneumonia</u> DUE TO (b) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u></u> DUE TO (c) <u></u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic Heart Disease</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>			
20c. TIME OF INJURY Month, Day, Year Hour <u></u> o. m. <u></u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	
20f. (City or town) <u></u> (County) <u></u> (State) <u></u>							
21. I certify that (I) (this hospital) attended the deceased from <u>10/1 1958</u> to <u>2/18 1961</u> , that (I) (we) lost saw the deceased alive on <u>2/18 1961</u> and that death occurred at <u>5 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Thomas S. Sappington</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <u>2/18/61</u>			
22c. PHYSICIAN'S NAME (Type) <u>THOMAS S. SAPPINGTON</u>				22d. ADDRESS <u>1025 CONNECTICUT AVE N.W.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/21/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Reform Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Middletown, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u>				25a. REC'D BY REGISTRAR <u>Arthur S. Kraus</u>		25b. REGISTRAR'S SIGNATURE <u>DATE FEB 21 '61</u>	

TO HOSPITAL OR AT HOME: The law requires that the death certificate be executed within 24 hours after a death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CERTIFICATE OF DEATH

1912

1

Full Name of Deceased *Robert A. Papprey*  
Date of Birth *May 10, 1875*  
Place of Birth *St. Louis, Mo.*  
Cause of Death *Heart Disease*  
Date of Death *May 10, 1912*  
Place of Death *St. Louis, Mo.*  
Signature of Physician *Robert A. Papprey*  
Signature of Undertaker *Robert A. Papprey*  
Signature of Registrar *Robert A. Papprey*

Full Name of Deceased *Robert A. Papprey*  
Date of Birth *May 10, 1875*  
Place of Birth *St. Louis, Mo.*  
Cause of Death *Heart Disease*  
Date of Death *May 10, 1912*  
Place of Death *St. Louis, Mo.*  
Signature of Physician *Robert A. Papprey*  
Signature of Undertaker *Robert A. Papprey*  
Signature of Registrar *Robert A. Papprey*

TO HOSPITAL OR FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

2130

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

02107

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN 1b <i>22 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Washington Sanitarium and Hospital</i>		d. STREET ADDRESS <i>1804 University Blvd. East.</i>		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>MAUDE</i> First <i>CARRIE</i> Middle <i>Middlekauff</i> Last		4. DATE OF DEATH <i>February 27 1961</i>		9. AGE (In years last birthday) <i>70 yrs.</i>	
5. SEX <i>female</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife Clerk</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Lansburgh's Dept. Store</i>		11. BIRTHPLACE (County & State, or foreign country) <i>West Virginia</i>	
13. FATHER'S NAME <i>Mr. Elmer E. Haney</i>		14. MOTHER'S MAIDEN NAME <i>Emma Hill</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>		16. SOCIAL SECURITY NO. <i>162-14-5455</i>		17. INFORMANT <i>Washington Sanitarium and Hospital Records</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hepatic failure</i> 155.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Carcinoma of Gallbladder.</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): INTERVAL BETWEEN ONSET AND DEATH <i>24 hours</i> <i>2 mos.</i>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Feb 15th 1961</i> to <i>Feb 26 1961</i> , that (I) (we) last saw the deceased alive on <i>Feb 26 1961</i> , and that death occurred at <i>5 PM</i> , from the causes and on the date stated above.					
22a. SIGNATURE <i>Lysle Williams</i> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>2/27/61</i>	
22c. PHYSICIAN'S NAME (Type) <i>Lysle Williams</i>		22d. ADDRESS <i>8700 Colesville Rd Silver Spring, Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE THEREOF <i>3/1/61</i>		23c. NAME OF CEMETERY OR CREMATORY <i>FT. LINCOLN CEMETERY</i>	
23d. LOCATION (City, town or county) <i>PRINCE GEO. COUNTY, MD.</i>		23e. REC'D BY REGISTRAR <i>DATE MAR 6 '61</i>		23f. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Raymond H. Ziska</i>		24b. ADDRESS <i>SILVER SPRING, MD.</i>			

2130



UNITED STATES DEPARTMENT OF THE INTERIOR  
BUREAU OF LAND MANAGEMENT  
WASHINGTON, D. C. 20250



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any cause is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 02108

2131

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>D.O.A</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium</u>				d. STREET ADDRESS <u>7108 Maple Ave</u>			
3. NAME OF DECEASED (Type or print) First <u>David</u> Middle <u>MAX</u> Last <u>MIEDZYNSKI</u>				4. DATE OF DEATH Month <u>Feb</u> Day <u>15</u> Year <u>1961</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u> <u>Jewish</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 9, 1919</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MERCHANT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>GROCERY</u>		9. AGE (In years last birthday) <u>41</u> yrs.		11. BIRTHPLACE (State or foreign country) <u>Poland</u>	
13. FATHER'S NAME <u>Moses MIEDZYNSKI</u>				12. CITIZEN OF WHAT COUNTRY? <u>ISRAEL</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>578-56-0900</u>			
17. INFORMANT <u>MR. ELY WEINKRANZ</u>				Address <u>7125 Maple Ave</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschert</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED <u>2-15-61</u>			
				Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2-16-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MT. LEBANON CEMETERY</u>		22d. LOCATION (City, town, or country) (State) <u>HYATTSVILLE MD.</u>	
23. FUNERAL DIRECTOR <u>B. Sanyanovsky &amp; Sons</u>				ADDRESS <u>3501-14th St NW</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 20 '61</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>			

MEDICAL CERTIFICATION

1818

NAVY AND STATE DEPARTMENT OF HEALTH



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NAVY AND STATE DEPARTMENT OF HEALTH

NAVY AND STATE DEPARTMENT OF HEALTH

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

2132

02109

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. LENGTH OF STAY IN 1b <u>15 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>10410 Clinton AVENUE</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Raymond</u> Last <u>Mills</u>				4. DATE OF DEATH Month <u>Feb</u> Day <u>11</u> Year <u>1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov 22 1888</u>	
9. AGE (In years lost birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lithographer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Printing</u>		11. BIRTHPLACE (State or foreign country) <u>Dist. of Columbia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>William H. Mills</u>				14. MOTHER'S MAIDEN NAME <u>Amy H. Henninger</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>x 577-05-2744</u>		17. INFORMANT Address <u>Mrs. Clara F. Mills - Same Address</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u>  </u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>2 1/2 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>JAN 14 1958</u> to <u>Feb 11 1961</u> , that (I) (we) last saw the deceased alive on <u>Feb 11 1961</u> , and that death occurred at <u>6:55 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>John Lawrence Avery</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>Feb 11 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>John Lawrence Avery</u>				22d. ADDRESS <u>10110 Georgia Ave., Silver Spring, Md.</u>			
23a. BURIAL/CREMATION DATE <u>2/15/61</u>		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVET CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>WASHINGTON, D.C.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Glick</u> INC.				ADDRESS <u>SILVER SPRING, MD.</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 16 '61</u>	
				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			

STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
OFFICE OF THE COMMISSIONER  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

5188

1

NAME OF DECEASED  
DATE OF DEATH  
PLACE OF DEATH  
CAUSE OF DEATH  
MANNER OF DEATH  
AGE AT DEATH  
SEX  
RACE  
EDUCATION  
OCCUPATION  
MARRIAGE  
RELIGION  
BIRTH DATE  
BIRTH PLACE  
BIRTH RACE  
BIRTH SEX  
BIRTH AGE  
BIRTH MARRIAGE  
BIRTH RELIGION  
BIRTH OCCUPATION  
BIRTH MANNER OF DEATH  
BIRTH CAUSE OF DEATH  
BIRTH PLACE OF DEATH  
BIRTH DATE OF DEATH  
BIRTH NAME OF DECEASED



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1970-1971

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2134

CERTIFICATE OF DEATH

Reg. Dist. No. 02111

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>08</u> <u>Emmetsburg</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				d. STREET ADDRESS <u>Rte # Emory Grove Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>BABY</u> Middle <u>Boy</u> Last <u>MOODY</u>				4. DATE OF DEATH Month <u>February</u> Day <u>15</u> Year <u>1961</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/15/61</u>		9. AGE (In years, last birthday) yrs. <u>8</u> Min. <u>5</u>	IF UNDER 1 YEAR Months <u>8</u> Days <u>5</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>THOMAS MOODY</u>				14. MOTHER'S MAIDEN NAME <u>GLORIA EXCHELBERGER WATERS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>		INFORMANT <u>MOTHER</u>		Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: <u>762.0</u> DUE TO <u>Fetal atelectasis</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>—</u> DUE TO <u>—</u> (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH <u>8h 5min</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u>—</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2/15</u> , 19 <u>61</u> , to <u>2/15</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>2/15</u> , 19 <u>61</u> , and that death occurred at <u>3:45</u> P. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>4740 Branley Blvd CHCH Md</u> DATE SIGNED <u>—</u>							
ACTUAL SIGNATURE <u>M. H. Swensen</u> M.D.				PHYSICIAN'S NAME (Type) <u>—</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>2-16-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Suburban Hospital</u>		22d. LOCATION (City, town, or county) (State) <u>Bethesda, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Mrs. Amelia Carter, Administrator</u>				24a. REC'D BY REGISTRAR <u>—</u> DATE <u>FEB 23 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Frank</u>	

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0513

CERTIFICATE OF DEATH

0513



*[Faint, mostly illegible text and lines on a certificate form, likely containing fields for name, date, and cause of death.]*



TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 3 and 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
2135											
02112											
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN lb <b>2 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>U. S. Naval Hospital</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Pennsylvania</b> b. COUNTY <b>Harrisburg</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>75X-3</b> d. STREET ADDRESS <b>3970 Green Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Walter Mann MUMMA</b>			4. DATE OF DEATH Month <b>February</b> Day <b>25</b> Year <b>1961</b>			5. SEX <b>Male</b>			6. COLOR OR RACE <b>Caucasian</b>		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			8. DATE OF BIRTH <b>11-20-90</b>			9. AGE (In years last birthday) <b>70 yrs.</b>			IF UNDER 1 YEAR Months <b>70</b> Days <b>70</b> Hours <b>70</b> Min. <b>70</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Congressman</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. House of Rep.</b>			11. BIRTHPLACE (County & State, or foreign country) <b>Pennsylvania</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Christian N. MUMMA</b>			14. MOTHER'S MAIDEN NAME <b>Agnès SHOPE</b>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>(S) Robt. M. Mumma, Pennsboro Manor, Wormleysburg Pa.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular Accident</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 20g. (City or town) (County) (State) 21. I certify that (X) (this hospital) attended the deceased from <b>Feb. 23 1961</b> to <b>Feb. 25 1961</b> , that (X) (we) last saw the deceased alive on <b>Feb. 25 1961</b> , and that death occurred at <b>3:30 PM</b> , from the causes and on the date stated above. 22a. SIGNATURE <b>J. J. CAVANAGH</b> M.D. 22b. DATE SIGNED <b>2-25-61</b> 22c. PHYSICIAN'S NAME (Type) <b>J. J. CAVANAGH, LT, MC, USN</b> 22d. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b> 22e. REC'D BY REGISTRAR <b>U. S. Naval Hospital, Bethesda, Md.</b> 22f. REGISTRAR'S SIGNATURE <b>Arthur S. Klaus</b>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>2-28-61</b>			23c. NAME OF CEMETERY OR CREMATORY <b>East Harrisburg Cemetery</b>			23d. LOCATION (City, town or county) (State) <b>Harrisburg Pennsylvania</b>		
24. FUNERAL DIRECTOR'S SIGNATURE <b>Jos. Gawler's Sons</b>			ADDRESS <b>WashDC</b>			25a. REC'D BY REGISTRAR <b>FEB 28 '61</b>			25b. REGISTRAR'S SIGNATURE <b>Arthur S. Klaus</b>		

8135

US115

Philadelphia

Philadelphia

Harrisburg

S. C. Davis

Harrisburg (Harris)

U.S. Green Office

U. S. Naval Hospital

Philadelphia

WOMAN

Hand

Walter

11-20-33

Chesapeake

Wife

U.S.A.

Philadelphia

U. S. House of Reps.

Commission

James H. Brown

Christopher H. Brown

(b) Brown, H. James, Philadelphia, Pennsylvania

No

Philadelphia, Pennsylvania

1933

1933

1933

1933

U. S. Naval Hospital, Bethesda, Md.

U. S. Naval Hospital, Bethesda, Md.

Philadelphia

U.S. House of Representatives

1933

1933

Joe. Gavril's Sons Funeral Home, 1725 W. Ave. 12, Philadelphia, Pa.

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2136  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

02113

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN lb <b>171 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>a. a.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b> d. STREET ADDRESS <b>418 6th Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Olga</b> Middle <b>Maria</b> Last <b>NYMAN</b>				4. DATE OF DEATH Month <b>February</b> Day <b>9</b> Year <b>1961</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Caucasian</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5-29-80</b>	
9. AGE (In years last birthday) <b>80</b> yrs.		IF UNDER 1 YEAR Months <b>80</b>		IF UNDER 24 HRS. Hours <b>80</b>		Min. <b>80</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>- - - - -</b>		11. BIRTHPLACE (State or foreign country) <b>Finland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>David TENHUNEN</b>				14. MOTHER'S MAIDEN NAME <b>Maria (Unknown)</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>(S) Benj. Nyman, sae as #2 above</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Toxemia, generalized</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Pemphigus vulgaris</b> DUE TO (c) <b>10 yrs.</b>						INTERVAL BETWEEN ONSET AND DEATH <b>1 month</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <b>U</b> (this hospital) attended the deceased from <b>August 22, 1960</b> to <b>Feb. 9, 1961</b> that <b>U</b> (we) last saw the deceased alive on <b>Feb. 9, 1961</b> , and that death occurred at <b>3:31AM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>R. W. Jones</b>				22b. DATE <b>2-9-61</b>		22c. PHYSICIAN'S NAME (Type) <b>R. W. JONES, CDR, MC, USN</b>	
22d. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2-13-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Naval Academy Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Annapolis Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>B. L. Hopping &amp; Son Funeral Home, Annapolis, Md.</b>				25a. REC'D BY REGISTRAR <b>FEB 10 '61</b>		25b. REGISTRAR'S SIGNATURE <b>John L. Haines</b>	

9138

CENTRAL CASE OF LEAD

WATSON, MARY

WATSON, (Mrs.)

U. S. Naval Hospital

WATSON, MARY

WATSON, (Mrs.)

U. S. Naval Hospital

WATSON, MARY

WATSON, (Mrs.)

U. S. Naval Hospital

WATSON, MARY

WATSON, (Mrs.)

(3) Mrs. Mary, age 45 years

WATSON, MARY

WATSON, (Mrs.)

U. S. Naval Hospital, Bethesda, Md.

U. S. Naval Hospital, Bethesda, Md.

U. S. Naval Hospital, Bethesda, Md.

U. S. Naval Hospital, Bethesda, Md.



**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

2137

## CERTIFICATE OF DEATH

02114

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		2. USUAL RESIDENCE (Where deceased lived, if institutions: Residence before admission) a. STATE <b>District of Columbia</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		b. COUNTY <b>Washington</b>	
c. LENGTH OF STAY IN b. <b>1 hr. 35 min.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>U. S. Naval Hospital,</b>		d. STREET ADDRESS <b>3801 Benton Street, N.W.</b>	
3. NAME OF DECEASED (Type or print) <b>Daniel Joseph O'BRIEN</b>		4. DATE OF DEATH <b>February 20 1961</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Caucasian</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></b>		8. DATE OF BIRTH <b>8-30-91</b>	
9. AGE (In years last birthday) <b>69</b> yrs.		10. IF UNDER 1 YEAR Months Days <b>February 20 1961</b>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Officer</b>		12. BIRTHPLACE (County & State, or foreign country) <b>Nevada</b>	
13. FATHER'S NAME <b>William O'BRIEN</b>		14. MOTHER'S MAIDEN NAME <b>Mary MC CARTY</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>1910 to 1953</b>	
17. INFORMANT <b>Hospital Records</b>		18. ADDRESS <b>U.S.A.</b>	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Infarction, myocardium</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) <b>Years</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 hours</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>420.0</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <b>(Signature)</b> attended the deceased from <b>Feb. 20 1960</b> to <b>Feb. 20 1961</b> , that (I) <b>(Signature)</b> last saw the deceased alive on <b>Feb. 20 1961</b> , and that death occurred at <b>8:20AM</b> , from the causes and on the date stated above		22a. SIGNATURE <b>Russell Miller, Jr. LT (MC) USN</b>	
22b. DATE SIGNED <b>2-20-61</b>		22c. PHYSICIAN'S NAME (Type) <b>Russell MILLER, JR., LT, MSE, USN</b>	
22d. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	
23b. DATE THEREOF <b>2-23-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>	
23d. LOCATION (City, town or county) (State) <b>Arlington Virginia</b>		24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. DeVol</b>	
24a. ADDRESS <b>DeVol Funeral Home, 2224 Wisc. Ave. NW, Wash DC</b>		24b. REC'D BY REGISTRAR <b>FEB 21 1961</b>	
24c. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>		24d. DATE <b>FEB 21 1961</b>	



## CERTIFICATE OF DEATH

Reg. Dist. No. 02115

2138

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write <b>SILVER SPRING</b> ) RURAL and give nearest town		c. CITY OR TOWN (If outside corporate limits, write <b>SILVER SPRING</b> ) RURAL and give nearest town	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>8403 HARTFORD AVENUE</b>		d. STREET ADDRESS <b>18403 Hartford Ave</b>	
3. NAME OF DECEASED (Type or print) <b>Edward Francis O'Connor</b>		4. DATE OF DEATH Month <b>FEB.</b> Day <b>10</b> Year <b>19 61</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/16/97</b>
9. AGE (In years lost birthday) <b>63</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bus operator, retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>D. C. Transit</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>US.A.</b>	
13. FATHER'S NAME <b>MICHAEL J. O'CONNOR</b>		14. MOTHER'S MAIDEN NAME <b>MARGARET MURPHY</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>578-10-7605</b>	
17. INFORMANT <b>Mrs. Ernest F. Knighting, 8403 Hartford Ave.</b>		Address <b>Silver Spring, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>153.8</b> DUE TO <b>Carcinoma Colon</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>Carcinoma Colon</b> DUE TO <b>Carcinoma Colon</b> DUE TO <b>Carcinoma Colon</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Dec</b> , 19 <b>50</b> , to <b>2/10</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>2/8</b> , 19 <b>61</b> , and that death occurred at <b>6:05</b> <b>A</b> .M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>W. Fleet Lockett</b>		ADDRESS (Street, city or town, State) <b>5000 Reno Rd NW</b> DATE SIGNED <b>2/10/61</b>	
PHYSICIAN'S NAME (Type) <b>W. FLEET LUCKETT</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>2/13/61</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>CEDAR HILL CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>PRINCE GEO. COUNTY, MARYLAND</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>WAGNER E. PUMPHREY, INC.</b> ADDRESS <b>SILVER SPRING, MD.</b>		24a. REC'D BY REGISTRAR <b>FEB 15 '61</b>	
24b. REGISTRAR'S SIGNATURE <b>Charles S. Kline</b>			

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

9438

WILLIAM

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
2139 CERTIFICATE OF DEATH 02116											
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Virginia</b> b. COUNTY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fairland</b>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Colonial Beach</b>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Fairland Nursing Home</b>						d. STREET ADDRESS <b>83X-3</b>					
3. NAME OF DECEASED (Type or print) <b>BARBARA W. OERTEL</b>						4. DATE OF DEATH Month <b>Feb.</b> Day <b>8</b> Year <b>1961</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 22, 1882</b>		9. AGE (In years last birthday) <b>78</b> yrs.		10. IF UNDER 1 YEAR Months <b>11</b> Days <b>17</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>				11. BIRTHPLACE (County & State, or foreign country) <b>Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>George W. Iste</b>						14. MOTHER'S MAIDEN NAME <b>Sally Mae Westland</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>step-grandson</b> <b>Charles Oertel, Bethesda, Md.</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma</b> <b>154X</b> DUE TO (b) <b>Adeno Ca Rectum -</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour <b>e.m.</b> p.m. <b>19</b>		Month, Day, Year		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Feb 8<sup>th</sup> 1961</b> , to <b>Feb 8<sup>th</sup> 1961</b> , that (I) (we) last saw the deceased alive on <b>Feb 8<sup>th</sup> 1961</b> , and that death occurred at <b>6:45 AM</b> , from the causes and on the date stated above.											
22a. SIGNATURE <b>Robert Kramer</b>						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>Feb 9<sup>th</sup> 1961</b>			
22c. PHYSICIAN'S NAME (Type) <b>ROBERT KRAMER</b>						22d. ADDRESS <b>1703 EAST-WEST Highway SS. Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/13/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat. Cem.</b>		23d. LOCATION (City, town or county) <b>Arlington, Virginia</b>		(State)			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>						ADDRESS <b>Bethesda, Maryland</b>		25a. REC'D BY REGISTRAR <b>FEB 15 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Clifford L. Hines</b>	

8113

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2/12/51

Washington Nat. Co.

Robert A. Humphrey, Maryland



1

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

02117

2140

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN lb <b>112 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>West Virginia</b> b. COUNTY <b>Charleston</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Louis</b> Middle <b>Ralph</b> Last <b>Olian</b>				4. DATE OF DEATH Month <b>February</b> Day <b>16</b> Year <b>19 61</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 19, 1922</b>	
9. AGE (In years last birthday) <b>38</b> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machine operator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>		11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Gayton Olian</b>		14. MOTHER'S MAIDEN NAME <b>Mary L. Olian</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>	
16. SOCIAL SECURITY NO. <b>236-22-6196</b>		17. INFORMANT <b>The Medical Record</b>		18. ADDRESS <b>The Clinical Center, Bethesda 14, Maryland</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Septicemia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Acute Myelogenous Leukemia</b> DUE TO (c) <b>Paraplegia</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Paraplegia</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>October 27, 19 60</b> to <b>February 16, 19 61</b> that (I) (we) last saw the deceased alive on <b>February 16, 19 61</b> , and that death occurred <b>3:30 AM</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Edward E. Morse</b>				22b. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Maryland</b>		22c. PHYSICIAN'S NAME (Type) <b>EDWARD E. MORSE, M.D.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-transit 2-16-61</b>		23b. DATE THEREOF <b>2-16-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Spring Hill Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Charleston, West Virginia</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>ROBERT A. PUMPHREY</b>				25a. REC'D BY REGISTRAR DATE <b>FEB 17 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>	

CERTIFICATE OF DEATH

5110

NAME: [illegible]  
AGE: [illegible]  
SEX: [illegible]  
DATE OF BIRTH: [illegible]  
PLACE OF BIRTH: [illegible]  
DATE OF DEATH: [illegible]  
PLACE OF DEATH: [illegible]  
CAUSE OF DEATH: [illegible]  
MANNER OF DEATH: [illegible]  
SIGNATURE: [illegible]  
DATE: [illegible]

REGISTRATION NO. [illegible]  
OFFICE OF THE REGISTRAR [illegible]  
[illegible text at bottom]

TO HOSPITAL OR FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Page 3 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
2141 Items 6, 13 & 14 Film G281 2/23/61 mh											
02118											
1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b>				b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>TAKOMA PARK</b>				c. LENGTH OF STAY IN 1b <b>15 days</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>WASHINGTON Sanitarium &amp; Hosp.</b>				e. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>West Hyattsville</b>				d. STREET ADDRESS <b>7602 25th Ave.</b>			
5. SEX <b>Female</b>				6. COLOR OR RACE <b>White Amer.</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF DEATH <b>2 2 1961</b>		9. AGE (In years last birthday) <b>78 yrs.</b>	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Joseph Patterson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>No</b>		17. INFORMANT <b>Hospital Records</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b> 331X DUE TO (b) <b>Previous Cerebral Vascular Accident</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>HyperTension</b>		INTERVAL BETWEEN ONSET AND DEATH <b>12 hours</b> <b>14 days</b> <b>Unknown</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Diabetes Mellitus</b>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>1-18</b>		20g. (County) <b>2-2</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>1-18</b> , 19 <b>61</b> , to <b>2-2</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>2-1</b> , 19 <b>61</b> , and that death occurred at <b>2:24 PM</b> , from the causes and on the date stated above.											
22a. SIGNATURE <b>Arthur L. Nelson</b>				22b. DATE SIGNED <b>2-2-61</b>		22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS		22e. REC'D BY REGISTRAR <b>2-2-61</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>				23b. DATE THEREOF <b>2/6/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MT. OLIVET CEMETERY</b>		23d. LOCATION (City, town or county) <b>WASH. D.C.</b>		23e. REGISTRAR'S SIGNATURE <b>Arthur L. Nelson</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>HARLON FUNERAL HOME - 3831-GR AVE N.W.</b>				25a. ADDRESS <b>DATE FEB 17 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Nelson</b>		25c. DATE		25d. REGISTRAR'S SIGNATURE	

1911

1911

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

2142

02119

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sakons Park</u> c. LENGTH OF STAY IN 1b <u>8 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington San. &amp; Hosp.</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institutions: Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Mont</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>19 SAKOMA PARK</u> d. STREET ADDRESS <u>18303 Haddon Drive</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) <u>Julius August Perlbachs</u> First Middle Last <b>5. SEX</b> <u>Male</u> <b>6. COLOR OR RACE</b> <u>White</u> <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>12/4/98</u> <b>9. AGE</b> (In years last birthday) <u>62</u> yrs. IF UNDER 1 YEAR: Months <u>2</u> Days <u>25</u> IF UNDER 24 HRS.: Hours <u>19</u> Min. <u>61</u>				<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>accountant</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Hospital</u> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Latvia</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>AMERICA</u>					
<b>13. FATHER'S NAME</b> <u>Woldemars Perlbachs</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Eva Udris</u>				<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u> (If yes give year or dates of service) <b>16. SOCIAL SECURITY NO.</b> <b>17. INFORMANT</b> <u>pt hospital record.</u> Address					
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ac Anterior Myocardial Infarction</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c)								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)				<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>	
<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)			
<b>21. I certify</b> that (I) (this hospital) attended the deceased from <u>2/17</u> to <u>2/25</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>2/25</u> , 19 <u>61</u> , and that death occurred at <u>2:15</u> P.M., from the causes and on the date stated above.									
<b>22a. SIGNATURE</b> <u>Charles H. Wolohon</u> M.D. <b>22c. PHYSICIAN'S NAME</b> (Type) <u>Charles H. Wolohon</u>				<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/> <b>22d. ADDRESS</b> <u>500 Unadwalk St. NW, Wash. DC</u>				<b>22b. DATE SIGNED</b>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Interred</u>		<b>23b. DATE THEREOF</b> <u>Feb-19-61</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Rock Creek Cemetery</u>		<b>23d. LOCATION</b> (City, town or county) (State) <u>Washington DC</u>			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>[Signature]</u> ADDRESS <u>254 Carroll St. N.W. D.C.</u>				<b>25a. REC'D BY REGISTRAR</b> DATE <u>FEB 28 '61</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>[Signature]</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
 15M 9/60

181

1115

(M)

John H. ...

John H. ...  
...



TO HOSPITAL OR FUNERAL HOME: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
2143 CERTIFICATE OF DEATH 02120											
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b> c. LENGTH OF STAY IN 1b <b>—</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>10709 Glenwild Road</b>						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b> d. STREET ADDRESS <b>10709 Glenwild Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Wilmar Bruun Petersen</b> First Middle Last <b>Wilmar Bruun Petersen</b>						4. DATE OF DEATH Month Day Year <b>Feb 25 1961</b>					
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2/8/1907</b>		9. AGE (In years last birthday) <b>54</b> yrs.		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Assistant Chief of Repair-Maritime</b>						10b. KIND OF BUSINESS OR INDUSTRY <b>Denmark</b>		11. BIRTHPLACE (County & State, or foreign country) <b>U.S.A.</b>			
13. FATHER'S NAME <b>Alfred Petersen</b>						14. MOTHER'S MAIDEN NAME <b>Marie Bruun</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes give war or dates of service)						16. SOCIAL SECURITY NO. <b>579-05-7073</b>		17. INFORMANT Address <b>Mrs. Ragnhild Petersen-Rd. S.S. Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute myocardial infarction</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>coronary atherosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH <b>3 hrs</b>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>Feb 25 1961</b> to <b>Feb 25 1961</b> , that (I) (we) last saw the deceased alive on <b>Feb 25 1961</b> , and that death occurred at <b>2 A.M.</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>H. F. Kreuzburg</b>						22b. DATE SIGNED <b>2/25/61</b>		22c. PHYSICIAN'S NAME (Type) <b>H. F. Kreuzburg</b>			
22d. ADDRESS <b>7852 16th St NW Wash DC</b>						22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>2/28/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>National Memorial Park Falls Church, Virginia</b>		23d. LOCATION (City, town or county) (State)			
24. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co.</b>						25a. REC'D BY REGISTRAR <b>FEB 27 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>			

1913

Long City

Given

1905

Given

Wife

Assistant Chief of Police

Alfred

1913-1914

1905

Chief of Police  
National Memorial Park  
Washington D.C.

## CERTIFICATE OF DEATH

Reg. Dist. No. **02121**

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TAKOMA PARK</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>WASHINGTON SANITARIUM &amp; HOSPITAL</b>		d. STREET ADDRESS <b>8735 CARROLL AVENUE</b>	
3. NAME OF DECEASED (Type or print) First <b>ROBERT</b> Middle <b>MORRIS</b> Last <b>PLOFF</b>		4. DATE OF DEATH Month <b>February</b> Day <b>9</b> Year <b>1961</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>DEC. 17, 1908</b>
9. AGE (In years last birthday) <b>52</b>		10. IF UNDER 1 YEAR Months <b>20</b> Days <b>1</b> Hours <b>1</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SALESMAN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>NEW YORK</b>	
11. BIRTHPLACE (State or foreign country) <b>NEW YORK</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>SAMUEL PLOFF</b>		14. MOTHER'S MAIDEN NAME <b>ROSE</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>LOUIS PLOFF</b>	
17. ADDRESS <b>719 UNIVERSITY BLVD., S.S., MD.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis acute</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Arteriosclerosis</b> DUE TO (c) <b>420.1</b> INTERVAL BETWEEN ONSET AND DEATH <b>4 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>225. 24, 1958</b> to <b>Jan 6, 1961</b> , that I last saw the deceased alive on <b>Jan 6, 1961</b> , and that death occurred at <b>6:49 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Bernard Danzansky</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>915-19th ST. N.W. Wash. D.C.</b>	
PHYSICIAN'S NAME (Type) <b>ISIDORE SHUKMAN</b>		M.D. <b>Wash. D.C.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>2-12-61</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>UNITED HEBREW CEM.</b>		22d. LOCATION (City, town, or county) (State) <b>BALTIMORE MD</b>	
23. BURIAL DIRECTOR'S SIGNATURE <b>BERNARD DANZANSKY &amp; SONS - 3501-14th St</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 14 '61</b>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <b>William J. Harris</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1941

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

2145

02122

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>5 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium + Hospital</u>			<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Prince George</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> d. STREET ADDRESS <u>8107 New Hampshire Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
<b>3. NAME OF DECEASED</b> (Type or print) <u>Alice Fanny Pope</u>		<b>4. DATE OF DEATH</b> Month <u>Feb.</u> Day <u>1</u> Year <u>1961</u>		<b>5. SEX</b> <u>Female</u> <b>6. COLOR OR RACE</b> <u>White</u> <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>4-12-90</u> <b>9. AGE</b> (In years last birthday) <u>70</u> yrs. <b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u> <b>IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>SCHOOL own Home</u> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Mass</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>		<b>13. FATHER'S NAME</b> <u>James H. Wild</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Alice Wardle</u>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u> <b>16. SOCIAL SECURITY NO.</b> <u>30-16-6304</u> <b>17. INFORMANT</b> <u>Hospital Records</u> Address <u>  </u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Hepatic failure</u> DUE TO (b) <u>Thrombosis Hepatic Vein (Budd-chiarì Syn.)</u> DUE TO (c) <u>  </u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. <u>583X</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>2 days.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Hiatal Hernia - post operation</u>				<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>  </u> <b>20f. (City or town)</b> <u>  </u> (County) <u>  </u> (State) <u>  </u>	
<b>21. I certify</b> that (I) (this hospital) attended the deceased from <u>Jan 26</u> , 19 <u>61</u> , to <u>Feb 1</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>Feb 1</u> , 19 <u>61</u> , and that death occurred at <u>7:54 AM</u> , from the causes and on the date stated above.					
<b>22a. SIGNATURE</b> <u>Lysle Williams</u> M.D.		<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <u>FEB 1, 1961</u>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>Lysle Williams</u>		<b>22d. ADDRESS</b> <u>8700 Colesville Rd Silver Spring, Md.</u>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>BURIAL</u>		<b>23b. DATE THEREOF</b> <u>2/6/61</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>ARLINGTON NAT'L. CEMETERY</u>	
<b>23d. LOCATION</b> (City, town or county) <u>ARLINGTON, VIRGINIA</u> (State) <u>  </u>		<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Raymond E. Pumphrey, INC.</u> ADDRESS <u>SILVER SPRING, MD.</u>			
<b>25a. REC'D BY REGISTRAR</b> DATE <u>FEB 9 '61</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kraus</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

5117

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James H. W. 19

Alison Wright  
Hosp. and Records

James H. W. 19

James H. W. 19

James H. W. 19



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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Item 8 FilmG281 2-27-61 et

## CERTIFICATE OF DEATH

Reg. Dist. No. 02123

2146

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Prince George</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Boysd</u>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>W. Hyattsville</u>		TOWN <u>1655-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Buck Lodge Nursing Home</u>				STREET ADDRESS (If rural give location) <u>2010 Bruce Street</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>EMMA</u> (Middle) <u>ELIZABETH</u> (Last) <u>POWELL</u>				(Month) <u>Feb.</u> (Day) <u>21</u> (Year) <u>1961</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>July 19, 1890</u>	9. AGE last birthday <u>90</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Fredrick W. Behrens</u>				14. MOTHER'S MAIDEN NAME <u>Rosa E.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Fredrick B. Powell, Alexandria, Va</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Bronchial Pneumonia</u>						<u>2 days</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Generalized Arteriosclerosis</u>						<u>2 years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>9 Jan.</u> , 19 <u>59</u> , to <u>21 Feb.</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>21 Feb.</u> , 19 <u>61</u> , and that death occurred at <u>7<sup>th</sup></u> A.M. from the causes and on the date stated above.							
SIGNATURE <u>Edna M. Smith</u>				ADDRESS (Street, city, town, state) <u>Barnesville</u>		DATE SIGNED <u>21 Feb 61</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Feb. 24, 1961</u>		NAME OF CEMETERY OR CREMATORY <u>Congressional Cemetery</u>		LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Arthur S. Francis</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters</u>		ADDRESS <u>254 Cornell St NW DC</u>	
DATE <u>FEB 23 '61</u>							

# CERTIFICATE OF DEATH

2148

1. LOCAL HEALTH DEPARTMENT OF DECEASED

NAME OF DECEASED  
 SEX  
 AGE  
 DATE OF BIRTH

RESIDENT OF  
 CITY  
 COUNTY

DATE OF DEATH  
 TIME OF DEATH  
 PLACE OF DEATH

STATE AND COUNTY

DATE

2. CAUSE OF DEATH  
 (To be filled in by the attending physician or medical examiner)  
 PRIMARY CAUSE  
 SECONDARY CAUSE  
 THIRD CAUSE

3. MANNER OF DEATH

4. PLACE OF DEATH

5. MEDICAL HISTORY

6. PHYSICAL EXAMINATION

7. LABORATORY EXAMINATIONS

8. POST-MORTEM EXAMINATION

9. TOXICOLOGICAL EXAMINATION

10. BACTERIOLOGICAL EXAMINATION

11. RADIOLOGICAL EXAMINATION

12. OTHER EXAMINATIONS

13. SIGNATURE OF PHYSICIAN

14. SIGNATURE OF MEDICAL EXAMINER

15. SIGNATURE OF CORONER

16. SIGNATURE OF JURY

17. SIGNATURE OF WITNESSES

18. SIGNATURE OF DECEASED

19. SIGNATURE OF NEAREST RELATIVE

20. SIGNATURE OF CLERGYMAN

21. SIGNATURE OF BURIAL OFFICIAL

22. SIGNATURE OF OTHER OFFICIALS

23. SIGNATURE OF OTHER OFFICIALS

24. SIGNATURE OF OTHER OFFICIALS

25. SIGNATURE OF OTHER OFFICIALS

26. SIGNATURE OF OTHER OFFICIALS

27. SIGNATURE OF OTHER OFFICIALS

28. SIGNATURE OF OTHER OFFICIALS

REMARKS

THIS CERTIFICATE IS TO BE FILED IN THE DEPARTMENT OF HEALTH, BALTIMORE, MD. AND A COPY IS TO BE FURNISHED TO THE LOCAL HEALTH DEPARTMENT OF THE CITY OR COUNTY WHERE THE DECEASED RESIDES. IT IS THE DUTY OF THE PHYSICIAN OR MEDICAL EXAMINER TO COMPLETE THIS CERTIFICATE AND SIGN IT. IT IS THE DUTY OF THE CORONER TO SIGN IT. IT IS THE DUTY OF THE JURY TO SIGN IT. IT IS THE DUTY OF THE WITNESSES TO SIGN IT. IT IS THE DUTY OF THE DECEASED TO SIGN IT. IT IS THE DUTY OF THE NEAREST RELATIVE TO SIGN IT. IT IS THE DUTY OF THE CLERGYMAN TO SIGN IT. IT IS THE DUTY OF THE BURIAL OFFICIAL TO SIGN IT. IT IS THE DUTY OF OTHER OFFICIALS TO SIGN IT.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G282 3-2-61 et

## CERTIFICATE OF DEATH

Reg. Dist. No.

2147

02124

1. PLACE OF DEATH o. COUNTY <b>MONTGOMERY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>PA.</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL Rockville</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>WAVERLEY SANITARIUM</b>				d. STREET ADDRESS <b>75X-3</b>			
3. NAME OF DECEASED (Type or print) First <b>ELLA</b> Middle <b>H</b> Last <b>PRESTON</b>				4. DATE OF DEATH Month <b>2</b> Day <b>13</b> Year <b>1961</b>			
5. SEX <b>FE</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept 23-1863</b>	9. AGE (In years last birthday) <b>97</b>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>		11. BIRTHPLACE (State or foreign country) <b>Norristown, Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>A.G. Rile</b>				14. MOTHER'S MAIDEN NAME <b>Sophia Alexander</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		INFORMANT Address <b>Hospital record</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Broncho pneumonia</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Congestive Heart Failure</b> DUE TO (c) <b>Arteriosclerotic Heart Disease</b>						INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>3 days</b> <b>10 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 1, 1953</b> to <b>Feb 18, 1961</b> , that I last saw the deceased alive on <b>Feb 17, 1961</b> , and that death occurred at <b>7:00 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Horace H. Custis Jr.</b>		ADDRESS (Street, city or town, state) <b>1852 Columbia Rd NW, Wash DC 2/18/61</b>					
PHYSICIAN'S NAME (Type) <b>HORACE H. CUSTIS JR</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		22b. DATE THEREOF <b>2-20-61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>		22d. LOCATION (City, town, or county) (State) <b>Prince George Co., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>ROBERT A. PUMPHREY</b>		ADDRESS <b>Bethesda, Md.</b>		24a. REC'D BY REGISTRAR <b>FEB 23 61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frame</b>	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2143

1. Name of deceased: [illegible]  
2. Sex: [illegible]  
3. Age: [illegible]  
4. Date of birth: [illegible]  
5. Date of death: [illegible]  
6. Place of death: [illegible]  
7. Cause of death: [illegible]  
8. Signature of physician: [illegible]  
9. Signature of registrar: [illegible]  
10. Date of registration: [illegible]

2148  
 MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
 CERTIFICATE OF DEATH

02125

1. PLACE OF DEATH o. COUNTY <b>MONTGOMERY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>DIST. OF COL.</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WASHINGTON.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>CONGRESSIONAL MANOR SANITARIUM</b>				d. STREET ADDRESS <b>3512-35 ST. N.W.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>Adele</b>		First <b>S.</b> Middle <b>Price</b> Last		4. DATE OF DEATH Month <b>Feb</b> Day <b>20</b> Year <b>1961</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-14-1875</b>		9. AGE (In years last birthday) <b>86</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>- - - -</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>IRVING SPENCE</b>				14. MOTHER'S MAIDEN NAME <b>- - PORNELL</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>- -</b>		17. INFORMANT <b>THOMAS M. PRICE</b> Address <b>WASH. D.C. 2202 KALORAMARON NW</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Renal failure</b> 600.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic pyelonephritis</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <b>5:30</b> a.m. <b>Feb 20</b> 1961		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1/31</b> 1961 to <b>2/20</b> 1961, that (I) (we) lost saw the deceased alive on <b>2-10</b> 1961, and that death occurred at <b>5:30</b> P.M. from the causes and on the date stated above.							
22a. SIGNATURE <b>William L. Howell</b> M.D.				22b. DATE SIGNED <b>Feb 20, 1961</b>			
22c. PHYSICIAN'S NAME (Type) <b>William L. Howell</b>				22d. ADDRESS <b>5401 Western Ave N.W.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		23b. DATE THEREOF <b>2-23-1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>DARLINGTON CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>DARLINGTON, MD.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph G. ...</b> ADDRESS <b>1756 Pa. Ave. NW</b>				25a. REC'D BY REGISTRAR DATE <b>FEB 23 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. ...</b>	

8148

8148

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

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FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
2149 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 02126

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>5 yrs</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>16 Silver Spring</u>		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>2025 Forest Hill Dr.</u>				d. STREET ADDRESS <u>12025 Forest Hill Dr</u>			
3. NAME OF DECEASED (Type or print) <u>Daniel Francis Quigley</u>				4. DATE OF DEATH <u>Feb 2 1961</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-6-1905</u>	
9. AGE (in years last birthday) <u>55 yrs.</u>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Manager Hardware store</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Man.</u>		11. BIRTHPLACE (State or foreign country) <u>M.S.A.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Daniel Quigley</u>				14. MOTHER'S MAIDEN NAME <u>Alice Calnan</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>578-05-4207</u>			
17. INFORMANT <u>Frances Quigley (wife)</u>				Address <u>Itm 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) } DUE TO (c) } PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschart</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED <u>2-2-61</u>			
				Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-6-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St Lincol Cemetery</u>		22d. LOCATION (City, town, or country) (State) <u>Prince Georges Maryland</u>	
23. FUNERAL DIRECTOR <u>Francis J. Collins</u>				ADDRESS <u>3821-14th St. N.W. Wash. D.C.</u>			
24a. REC'D BY REGISTRAR <u>FEB 6 '61</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanna</u>			

NAVY AND MARINE CORPS MEDICAL DEPARTMENT  
OFFICE OF THE SURGEON GENERAL  
WASHINGTON, D. C. 20340  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2111

NO. 1000  
10000000

250-03417

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

2150

02127

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY COUNTY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>3801 13th St. N. W. Washington, D. C.</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WHEATON, MARYLAND</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>11901 Georgia Ave.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>WHEATON NURSING HOME</b>		d. STREET ADDRESS <b>11901 Georgia Ave.</b>	
3. NAME OF DECEASED (Type or print) <b>CHRISTOPHER</b> First Middle Last		4. DATE OF DEATH Month <b>2</b> Day <b>20</b> Year <b>19 61</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/18/1867</b>
9. AGE (In years last birthday) <b>93</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>GERMANY</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>MICHAEL RAMMLING</b>		14. MOTHER'S MAIDEN NAME <b>HORNER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>?</b>	
17. INFORMANT <b>Nursing Home Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) <b>10-yr.</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>6 mos.</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1/5</b> 19 <b>45</b> to <b>2/20</b> 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>2/20</b> 19 <b>61</b> , and that death occurred at <b>4:15</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>John E. Everett</b>		22b. DATE SIGNED <b>2/20/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>JOHN E. EVERETT</b>		22d. ADDRESS <b>9400 Conn Ave Kensington Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>2/23/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Rock Creek Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Washington, D.C.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>John E. Everett</b>		25a. REC'D BY REGISTRAR <b>2901-1448-370</b>	
25b. REGISTRAR'S SIGNATURE <b>C. E. &amp; F. H. H.</b>		DATE <b>FEB 23 '61</b>	

MEDICAL CERTIFICATION

5150

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CHIEF OF POLICE

## CERTIFICATE OF DEATH

Reg. Dist. No.

02128

1. PLACE OF DEATH o. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>MONTG.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>KENSINGTON</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X SILVER SPRING</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>KENSINGTON GARDENS SAN.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MAX</b> Middle <b>RAPHAELSON</b> Last <b>RAPHAELSON</b>		4. DATE OF DEATH Month <b>2</b> - Day <b>17</b> - Year <b>1961</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>APR-23-1880</b>
9. AGE (In years last birthday) <b>80</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LITHOGRAPHER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. GOVT.</b>	
11. BIRTHPLACE (State or foreign country) <b>POLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>RAPHAEL KIMCHE</b>		14. MOTHER'S MAIDEN NAME <b>JUDITH</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>LEONA FRIEDMAN</b>		Address <b>810 HYDE CT. SSPG. MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>1977.3</b> DUE TO <b>transition</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>metastatic melanoma of rt. leg</b> DUE TO (c) <b>1 year</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>11-25</b> , 19 <b>57</b> to <b>2-17</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>2-16</b> , 19 <b>61</b> , and that death occurred at <b>1:35</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Jason Geiger</b>		ADDRESS (Street, city or town, state) <b>1110 SPRING ST. SILVER SPRING, MD.</b>	
PHYSICIAN'S NAME (Type) <b>JASON GEIGER</b>		DATE SIGNED <b>2-17-61</b>	
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>2/19/61</b>	22c. NAME OF CEMETERY OR CREMATORY <b>GEO. WASH. CEM.</b>	22d. LOCATION (City, town, or county) (State) <b>HYATTSVILLE, MD.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Goldberg Funeral Home</b>		24a. REC'D BY REGISTRAR <b>4217-9<sup>th</sup> St.</b>	24b. REGISTRAR'S SIGNATURE <b>DATE FEB 21 '61</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1351

PLACE OF BIRTH [Faint text]		SEX [Faint text]	
RACE [Faint text]		AGE [Faint text]	
DATE OF DEATH [Faint text]		TIME OF DEATH [Faint text]	
PLACE OF DEATH [Faint text]		CAUSE OF DEATH [Faint text]	
MANNER OF DEATH [Faint text]		MEDICAL HISTORY [Faint text]	
OCCUPATION [Faint text]		EDUCATION [Faint text]	
MARITAL STATUS [Faint text]		PREVIOUS ILLNESS [Faint text]	
SIGNATURE OF DECEASED [Faint text]		SIGNATURE OF WITNESS [Faint text]	
SIGNATURE OF PHYSICIAN [Faint text]		SIGNATURE OF CORONER [Faint text]	
SIGNATURE OF JURY [Faint text]		SIGNATURE OF JUDGE [Faint text]	



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

2152

02123

<b>1. PLACE OF DEATH</b> a. COUNTY <u>MONTGOMERY</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAYLOR PARK</u> c. LENGTH OF STAY IN lb d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>WASHINGTON SANITARIUM</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution; Residence before admission) a. STATE <u>MD</u> <span style="float: right;">b. COUNTY <u>Montgomery</u></span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING 32</u> d. STREET ADDRESS <u>1604 LADD ST</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>WILLIAM A. RAUCH</u>		<b>4. DATE OF DEATH</b> Month <u>Feb</u> Day <u>24</u> Year <u>1961</u>	
<b>5. SEX</b> <u>MALE</u>	<b>6. COLOR OR RACE</b> <u>WHITE</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>9-27-06</u>
<b>9. AGE</b> (In years last birthday) <u>54 yrs.</u>	<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Draftsman</u>	<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>WASHINGTON DC</u>	<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>
<b>13. FATHER'S NAME</b> <u>HARRY C RAUCH</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>MINNA BUCKEL</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service)		<b>16. SOCIAL SECURITY NO.</b> Address <u>MARY H. RAUCH 1604 Lodd St</u>	

<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>meningo-encephalitis</u> <u>340.1</u> DUE TO (b) <u>Pneumococcus infection</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c)		<b>INTERVAL BETWEEN ONSET AND DEATH</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER)	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>19</u> e.m. p.m.	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)
<b>21. I certify</b> that (I) (this hospital) attended the deceased from <u>Feb 23, 1961</u> , to <u>Feb 24, 1961</u> , that (I) ( <del>we</del> ) last saw the deceased alive on <u>Feb 24, 1961</u> , and that death occurred at <u>10:11 A.M.</u> from the causes and on the date stated above.		
<b>22a. SIGNATURE</b> <u>Edward J. Richards</u> M.D.	<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/> <b>22b. DATE SIGNED</b> <u>2-26-61</u>	<b>22c. PHYSICIAN'S NAME</b> (Type) <u>10110 GA. AVE Silver Spg</u>
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>	<b>23b. DATE THEREOF</b> <u>2-27-61</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Cedar Hill</u>
<b>23d. LOCATION</b> (City, town or county) (State) <u>Southland Md</u>		<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Neal Funeral Home</u> ADDRESS <u>4812 Ga Ave Wash DC</u>
<b>25a. REC'D BY REGISTRAR</b> DATE <u>MAR 1 '61</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur L. Harris</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

2175

MOUNT MEAD

TATUM PARK

WASHINGTON SANITARIUM

1000 ROAD 8

WILLIAM A RANCH

MAE WHITE 9-27-06 24

W. S. GAY

WASHINGTON DC

HARRY C RANCH

MIRIAM

BUCKER

MARY H RANCH 1000 ROAD 8

Ex. 1000

Ex. 1000

Ex. 1000

## CERTIFICATE OF DEATH

Reg. Dist. No. 02130

2153

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gaithersburg</b>				c. LENGTH OF STAY IN 1b <b>19 yrs</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Asbury Methodist Home</b>				d. STREET ADDRESS <b>697 Glalstone Ave.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Beulah</b> Middle <b>Ulrica</b> Last <b>Richards</b>				4. DATE OF DEATH Month <b>Feb.</b> Day <b>10</b> Year <b>1961</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 26, 1871</b>	
9. AGE (In years last birthday) <b>89 yrs.</b>		IF UNDER 1 YEAR Months <b>89</b> Days <b>89</b> Hours <b>89</b> Min. <b>89</b>		IF UNDER 24 HRS. Months <b>89</b> Days <b>89</b> Hours <b>89</b> Min. <b>89</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housekeeper</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Virginia</b>		11. BIRTHPLACE (State or foreign country) <b>U. S. A.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>Theodore Augusta Richards</b>				14. MOTHER'S MAIDEN NAME <b>Emma Frances Broughton</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>(If yes, give war or dates of service)</b>				16. SOCIAL SECURITY NO. <b>INFORMANT Address Gaithersburg</b> <b>Asbury Methodist Home Records. Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive - Arteriosclerotic Cardiovascular Disease</b> DUE TO (c) <b>Hypertensive - Arteriosclerotic Cardiovascular Disease</b>				INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypertensive - Arteriosclerotic Cardiovascular Disease</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>Oct 15, 1960</b> , to <b>Feb 10, 1961</b> , that I last saw the deceased alive on <b>Feb 7, 1961</b> , and that death occurred at <b>6:55 AM</b> , from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <b>7720 Wisconsin Ave. - Bethesda, Md.</b>			
ACTUAL SIGNATURE <b>James W. Egan</b>				DATE SIGNED <b>2-10-61</b>			
PHYSICIAN'S NAME (Type) <b>James W. Egan</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>2-13-61</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>Forest Oak</b>				22d. LOCATION (City, town, or county) (State) <b>Gaithersburg, Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ernest C. Gartner. Gaithersburg, Md.</b>				24a. REGD. BY REGISTRAR <b>FEB 14 1961</b>			
24b. REGISTRAR'S SIGNATURE <b>Ernest C. Gartner</b>							

TO HOSPITAL OR AT HOME: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1113

Decedent's Name: [illegible]  
Sex: [illegible] Age: [illegible]  
Race: [illegible] Birth Date: [illegible]

Place of Birth: [illegible] Date of Birth: [illegible]

Usual Residence: [illegible]  
Date of Death: [illegible]

U.S.A. [illegible]  
Cause of Death: [illegible]

Theodore Alexander [illegible]

Signature of [illegible]

[Faint, mostly illegible text at the bottom of the page, possibly containing additional medical or administrative notes.]

## CERTIFICATE OF DEATH

Reg. Dist. No. 02131

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Kensington Md</i>		c. LENGTH OF STAY IN 1b <i>3 months</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Carroll Hall Nursing Home</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cherry Chase Md 51</i>	
3. NAME OF DECEASED (Type or print) <i>LENO</i> First Middle Last <i>Ritter</i>		4. DATE OF DEATH <i>Feb. 5 1961</i> Month Day Year	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1-24-79</i>
9. AGE (In years last birthday) <i>82</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <i>at home</i>	
11. BIRTHPLACE (State or foreign country) <i>D.C.</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Carl Herfurth</i>		14. MOTHER'S MARDEN NAME <i>Margaret Dietz</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Chas. R. Ritter</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary insufficiency</i> <i>420.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Arteriosclerotic Heart Disease</i> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Fractured left hip</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Fall from bed.</i>	
20c. TIME OF INJURY Month Day Year Hour a. m. <i>6:30</i> p. m. <i>Oct. 24 1960</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>	20f. (City or town) (County) (State) <i>Cherry Chase Mont. Md.</i>
21. I certify that I attended the deceased from <i>10/28, 1961</i> , to <i>present</i> , 19 <i>61</i> , that I last saw the deceased alive on <i>1/30, 1961</i> , and that death occurred at <i>6 A.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>John B. Umhan</i>		M.D. <i>8805 Conn. Ave.</i> DATE SIGNED <i>2/5/61</i>	
PHYSICIAN'S NAME (Type) <i>John B. Umhan</i>		<i>Cherry Chase 15, Md</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <i>2-8-61</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill</i>	22d. LOCATION (City, town, or county) (State) <i>Smith and me</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>L. L. Funeral Home - P.C.</i>		ADDRESS	
24a. REC'D BY REGISTRAR DATE <i>FEB 8 '61</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hous</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2152

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male		3. AGE 68		4. RACE White		5. DATE OF BIRTH 1891		6. PLACE OF BIRTH Baltimore, Md.	
7. DATE OF DEATH 1952		8. PLACE OF DEATH Baltimore, Md.		9. CAUSE OF DEATH Heart Disease		10. MANNER OF DEATH Natural		11. SIGNATURE OF DECEASED James H. Harris		12. SIGNATURE OF WITNESSES John Doe, Jane Doe	
13. NAME OF PHYSICIAN Dr. John Doe		14. NAME OF HOSPITAL St. Mary's Hospital		15. NAME OF NURSE Mrs. Jane Doe		16. NAME OF BURIAL PLACE St. Mary's Cemetery		17. NAME OF MINISTER Rev. John Doe		18. NAME OF FUNERAL HOME John Doe & Co.	
19. NAME OF CORONER John Doe		20. NAME OF JURY John Doe, Jane Doe, Bob Doe		21. NAME OF JUDGE Judge John Doe		22. NAME OF CLERK John Doe		23. NAME OF RECORDS John Doe		24. NAME OF ARCHIVE John Doe	
25. NAME OF DECEASED'S NEXT OF KIN Mrs. Jane Harris		26. NAME OF DECEASED'S ADDRESS 123 Main St., Baltimore, Md.		27. NAME OF DECEASED'S OCCUPATION Teacher		28. NAME OF DECEASED'S RELIGION Roman Catholic		29. NAME OF DECEASED'S MARITAL STATUS Married		30. NAME OF DECEASED'S EDUCATION High School Graduate	
31. NAME OF DECEASED'S BIRTHPLACE Baltimore, Md.		32. NAME OF DECEASED'S CITIZENSHIP American		33. NAME OF DECEASED'S RESIDENCE Baltimore, Md.		34. NAME OF DECEASED'S EMPLOYER St. Mary's School		35. NAME OF DECEASED'S EMPLOYMENT Teacher		36. NAME OF DECEASED'S EMPLOYMENT Teacher	
37. NAME OF DECEASED'S EMPLOYMENT Teacher		38. NAME OF DECEASED'S EMPLOYMENT Teacher		39. NAME OF DECEASED'S EMPLOYMENT Teacher		40. NAME OF DECEASED'S EMPLOYMENT Teacher		41. NAME OF DECEASED'S EMPLOYMENT Teacher		42. NAME OF DECEASED'S EMPLOYMENT Teacher	
43. NAME OF DECEASED'S EMPLOYMENT Teacher		44. NAME OF DECEASED'S EMPLOYMENT Teacher		45. NAME OF DECEASED'S EMPLOYMENT Teacher		46. NAME OF DECEASED'S EMPLOYMENT Teacher		47. NAME OF DECEASED'S EMPLOYMENT Teacher		48. NAME OF DECEASED'S EMPLOYMENT Teacher	
49. NAME OF DECEASED'S EMPLOYMENT Teacher		50. NAME OF DECEASED'S EMPLOYMENT Teacher		51. NAME OF DECEASED'S EMPLOYMENT Teacher		52. NAME OF DECEASED'S EMPLOYMENT Teacher		53. NAME OF DECEASED'S EMPLOYMENT Teacher		54. NAME OF DECEASED'S EMPLOYMENT Teacher	
55. NAME OF DECEASED'S EMPLOYMENT Teacher		56. NAME OF DECEASED'S EMPLOYMENT Teacher		57. NAME OF DECEASED'S EMPLOYMENT Teacher		58. NAME OF DECEASED'S EMPLOYMENT Teacher		59. NAME OF DECEASED'S EMPLOYMENT Teacher		60. NAME OF DECEASED'S EMPLOYMENT Teacher	
61. NAME OF DECEASED'S EMPLOYMENT Teacher		62. NAME OF DECEASED'S EMPLOYMENT Teacher		63. NAME OF DECEASED'S EMPLOYMENT Teacher		64. NAME OF DECEASED'S EMPLOYMENT Teacher		65. NAME OF DECEASED'S EMPLOYMENT Teacher		66. NAME OF DECEASED'S EMPLOYMENT Teacher	
67. NAME OF DECEASED'S EMPLOYMENT Teacher		68. NAME OF DECEASED'S EMPLOYMENT Teacher		69. NAME OF DECEASED'S EMPLOYMENT Teacher		70. NAME OF DECEASED'S EMPLOYMENT Teacher		71. NAME OF DECEASED'S EMPLOYMENT Teacher		72. NAME OF DECEASED'S EMPLOYMENT Teacher	
73. NAME OF DECEASED'S EMPLOYMENT Teacher		74. NAME OF DECEASED'S EMPLOYMENT Teacher		75. NAME OF DECEASED'S EMPLOYMENT Teacher		76. NAME OF DECEASED'S EMPLOYMENT Teacher		77. NAME OF DECEASED'S EMPLOYMENT Teacher		78. NAME OF DECEASED'S EMPLOYMENT Teacher	
79. NAME OF DECEASED'S EMPLOYMENT Teacher		80. NAME OF DECEASED'S EMPLOYMENT Teacher		81. NAME OF DECEASED'S EMPLOYMENT Teacher		82. NAME OF DECEASED'S EMPLOYMENT Teacher		83. NAME OF DECEASED'S EMPLOYMENT Teacher		84. NAME OF DECEASED'S EMPLOYMENT Teacher	
85. NAME OF DECEASED'S EMPLOYMENT Teacher		86. NAME OF DECEASED'S EMPLOYMENT Teacher		87. NAME OF DECEASED'S EMPLOYMENT Teacher		88. NAME OF DECEASED'S EMPLOYMENT Teacher		89. NAME OF DECEASED'S EMPLOYMENT Teacher		90. NAME OF DECEASED'S EMPLOYMENT Teacher	
91. NAME OF DECEASED'S EMPLOYMENT Teacher		92. NAME OF DECEASED'S EMPLOYMENT Teacher		93. NAME OF DECEASED'S EMPLOYMENT Teacher		94. NAME OF DECEASED'S EMPLOYMENT Teacher		95. NAME OF DECEASED'S EMPLOYMENT Teacher		96. NAME OF DECEASED'S EMPLOYMENT Teacher	
97. NAME OF DECEASED'S EMPLOYMENT Teacher		98. NAME OF DECEASED'S EMPLOYMENT Teacher		99. NAME OF DECEASED'S EMPLOYMENT Teacher		100. NAME OF DECEASED'S EMPLOYMENT Teacher		101. NAME OF DECEASED'S EMPLOYMENT Teacher		102. NAME OF DECEASED'S EMPLOYMENT Teacher	
103. NAME OF DECEASED'S EMPLOYMENT Teacher		104. NAME OF DECEASED'S EMPLOYMENT Teacher		105. NAME OF DECEASED'S EMPLOYMENT Teacher		106. NAME OF DECEASED'S EMPLOYMENT Teacher		107. NAME OF DECEASED'S EMPLOYMENT Teacher		108. NAME OF DECEASED'S EMPLOYMENT Teacher	
109. NAME OF DECEASED'S EMPLOYMENT Teacher		110. NAME OF DECEASED'S EMPLOYMENT Teacher		111. NAME OF DECEASED'S EMPLOYMENT Teacher		112. NAME OF DECEASED'S EMPLOYMENT Teacher		113. NAME OF DECEASED'S EMPLOYMENT Teacher		114. NAME OF DECEASED'S EMPLOYMENT Teacher	
115. NAME OF DECEASED'S EMPLOYMENT Teacher		116. NAME OF DECEASED'S EMPLOYMENT Teacher		117. NAME OF DECEASED'S EMPLOYMENT Teacher		118. NAME OF DECEASED'S EMPLOYMENT Teacher		119. NAME OF DECEASED'S EMPLOYMENT Teacher		120. NAME OF DECEASED'S EMPLOYMENT Teacher	



2155

## CERTIFICATE OF DEATH

Reg. Dist. No. 02132

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>9117 GLENRIDGE ROAD</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>KENNETH</b> Middle <b>NORMAN</b> Last <b>RYAN</b>		4. DATE OF DEATH Month <b>FEB.</b> Day <b>1</b> Year <b>1961</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/27/02</b>
9. AGE (In years last birthday) <b>58</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Accounts officer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Gov't. Library of Congress</b>	
11. BIRTHPLACE (State or foreign country) <b>WEST VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JAMES RYAN</b>		14. MOTHER'S MAIDEN NAME <b>EDNA SALTER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>Mrs. Mary C. Ryan, 9117 Glenridge Road</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Artery Occlusion &amp; Extension</b> 42021 DUE TO <b>Chronic Arterio Sclerosis particularly Coronary Arteries</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO <b>Coronary Arteries</b> INTERVAL BETWEEN ONSET AND DEATH <b>10 hours - 4 Years</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Silver Spring, Md</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>January, 1950</b> to <b>2-1-1961</b> , that I last saw the deceased alive on <b>2-1-1961</b> , and that death occurred at <b>8:29 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>N. C. Shoemaker</b>		ADDRESS (Street, city or town, state) <b>8005 Woodbury Dr. Silver Spring, Md.</b>	
PHYSICIAN'S NAME (Type) <b>N. C. Shoemaker</b>		DATE SIGNED <b>2-1-61</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>2/4/61</b>	22c. NAME OF CEMETERY OR CREMATORY <b>GATE OF HEAVEN CEMETERY</b>	22d. LOCATION (City, town, or county) (State) <b>MONTGOMERY COUNTY, MD.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>WALTER E. PUMPHREY, INC.</b> <b>Raymond A. Giska</b>		24a. REC'D BY REGISTRAR <b>Arthur S. Kraus</b>	
ADDRESS <b>SILVER SPRING, MD.</b>		DATE <b>FEB 9 '61</b>	

CERTIFICATE OF DEATH

1918

DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE AT DEATH

SEX

RACE

RELIGION

EDUCATION

DATE

TIME

PLACE

NAME OF DECEASED

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

NAME OF DECEASED

SEX

CAUSE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

2156

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

02133

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda, (Rural)</b> c. LENGTH OF STAY IN lb <b>26 min.</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>District of Columbia</b> b. COUNTY <b>Washington,</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington,</b> d. STREET ADDRESS <b>364 Chaplin St., S. E.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>SEENEY</b>		4. DATE OF DEATH Month Day Year <b>February 5 1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-5-61</b>
9. AGE (In years last birthday) <b>26</b>		10. IF UNDER 1 YEAR Months Days Hours Min. <b>26</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -----		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Emmett Roland SEENEY</b>		14. MOTHER'S MAIDEN NAME <b>Joan M. WILLIAMS</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Anoxia</b> 782.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <b>neonatal atelectasis</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <b>26 min.</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <del>this hospital</del> attended the deceased from <b>Feb. 5 1961</b> to <b>Feb. 5 1961</b> , that (I) (we) last saw the deceased alive on <b>Feb. 5 1961</b> , and that death occurred at <b>1:05 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Robert V. Rack</b>		22b. DATE SIGNED <b>2-6-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Robert V. RACK, LT, MC, USN</b>		22d. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2-14-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>W.E. Jarvis Funeral Home, 1432 U St., NW, WashDC</b>		25a. REC'D BY REGISTRAR <b>FEB 10 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Colleen E. Evans</b>			

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COGNATE OF DEATH

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Page 4  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be returned to the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

2157

02134

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b>		c. LENGTH OF STAY IN 1b <b>19 DAYS</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>MONTGOMERY</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b>		d. STREET ADDRESS <b>1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>IRENE SHERMAN SELBY</b>		4. DATE OF DEATH Month <b>FEBRUARY 10</b>		Day <b>19</b>		Year <b>61</b>		5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>NEGRO</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>5/21/08</b>		9. AGE (In years last birthday) <b>52</b> yrs.		10. IF UNDER 1 YEAR Months <b>2</b> Days <b>10</b>		11. IF UNDER 24 HRS. Hours <b>10</b> Min. <b>61</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>DOMESTIC</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>MESSIAH ADDISON</b>		14. MOTHER'S MAIDEN NAME <b>ANNIE VIRGINIA WILLIAMS</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>1</b>		17. INFORMANT <b>HOSPITAL RECORDS, OLNEY, MD.</b>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>UREMIA</b> <b>592X</b> DUE TO <b>CHRONIC GLOMERULONEPHRITIS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>HYPERTENSIVE HEART DISEASE</b> (b) <b>HYPERTENSIVE HEART DISEASE</b> (c) <b>HYPERTENSIVE HEART DISEASE</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 WK</b> <b>YXS</b> <b>YXS</b>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from _____ 19____, to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that death occurred at _____ M., from the causes and on the date stated above.		22a. SIGNATURE <b>Charles H. Ligon</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>2/10/61</b>		22c. PHYSICIAN'S NAME (Type) <b>CHARLES H. LIGON, M. D.</b>		22d. ADDRESS <b>SANDY SPRING, MD.</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>2/13/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Zion.,</b>		23d. LOCATION (City, town, or county) <b>Mt. Zion, Md.</b>		(State)	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert L. Snowden</b>		ADDRESS <b>Rockville, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>FEB 15 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hearn</b>															

# CERTIFICATE OF DEATH

MONTGOMERY

MARYLAND

MONTGOMERY

CLINT

19 DAYS

CLINT

MONTGOMERY GENERAL HOSPITAL

CLINT

SHERMAN

JACOB

FEBRUARY 10 1961

51

2/10/61

X

RECORD

FEMALE

U. S. S.

MARYLAND

DOMESTIC

AMIE VIRGINIA WILLIAMS

HESSIAN ADOLPH

HOSPITAL RECORDS, CLINT, MD.

2/10/61

SANITARY SERVICE, MD.

CHARLES J. LLOYD, M.D.

1/1



Page 4  
TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death.  
TO ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

02135

1. PLACE OF DEATH a. COUNTY <b>Montgomery County</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gaithersburg</b>	
c. LENGTH OF STAY IN lb <b>9 days; 4 hrs; 48 min.</b>		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Montgomery General Hospital</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Teresa</b> Middle <b>Jane</b> Last <b>Selby</b>		4. DATE OF DEATH Month <b>February</b> Day <b>5</b> Year <b>1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 13 1865</b>
9. AGE (In years last birthday) <b>95</b> yrs.		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>United States</b>			
13. FATHER'S NAME <b>Jacob Arnold</b>		14. MOTHER'S MAIDEN NAME <b>Matilda Smith</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Hospital Records</b>	
17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b> 42 0.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <b>Arteriosclerosis, Generalized</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <b>Years</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan. 26, 1961</b> to <b>Feb. 5, 1961</b> , that (I) <del>was</del> lost saw the deceased alive on <b>Feb. 5, 1961</b> , and that death occurred at <b>7:30 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Jack Schumacher</b>		22b. DATE SIGNED <b>2-5-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Jack Schumacher</b>		22d. ADDRESS <b>Gaithersburg, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2-8-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Forest Oak</b>		23d. LOCATION (City, town, or county) (State) <b>Gaithersburg Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Ernest C. Gartner.</b>		ADDRESS <b>Gaithersburg, Md.</b>	
25a. REGISTRAR'S SIGNATURE <b>Ernest C. Gartner.</b>		25b. REGISTRAR'S SIGNATURE <b>Ernest C. Gartner.</b>	

UNITED STATES DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
STATE OF TEXAS  
1915

NAME: [illegible]  
SEX: [illegible]  
AGE: [illegible]  
DATE OF BIRTH: [illegible]  
PLACE OF BIRTH: [illegible]  
MARRIAGE: [illegible]  
OCCUPATION: [illegible]  
EDUCATION: [illegible]  
RELIGION: [illegible]  
MOTHER'S NAME: [illegible]  
FATHER'S NAME: [illegible]  
MARRIAGE DATE: [illegible]  
MARRIAGE PLACE: [illegible]  
MARRIAGE TYPE: [illegible]  
MARRIAGE DURATION: [illegible]  
MARRIAGE STATUS: [illegible]  
MARRIAGE RECORD: [illegible]  
MARRIAGE OFFICE: [illegible]  
MARRIAGE OFFICIAL: [illegible]  
MARRIAGE WITNESSES: [illegible]  
MARRIAGE CERTIFICATE: [illegible]  
MARRIAGE REGISTRATION: [illegible]  
MARRIAGE RECORDS: [illegible]  
MARRIAGE ARCHIVE: [illegible]  
MARRIAGE COLLECTION: [illegible]  
MARRIAGE DEPARTMENT: [illegible]  
MARRIAGE DIVISION: [illegible]  
MARRIAGE SECTION: [illegible]  
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MARRIAGE CERTIFICATE: [illegible]  
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MARRIAGE COLLECTION: [illegible]  
MARRIAGE DEPARTMENT: [illegible]  
MARRIAGE DIVISION: [illegible]  
MARRIAGE SECTION: [illegible]  
MARRIAGE UNIT: [illegible]

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 12 Film G281 2/23/61 mh

CERTIFICATE OF DEATH

Reg. Dist. No.

02136

2159

1. PLACE OF DEATH a. COUNTY <b>Montg,</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gaithersburg</b> c. LENGTH OF STAY IN 1b <b>12yrs</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montg</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gaithersburg</b> d. STREET ADDRESS <b>2-Cedar Ave</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Effie Pearl Shankle</b>				4. DATE OF DEATH <b>Feb 15 1961</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Dec 15-1903</b>	
9. AGE (In years last birthday) <b>57 yrs.</b>		10. IF UNDER 1 YEAR <b>2</b> Months		11. IF UNDER 24 HRS. <b>2</b> Days		12. IF UNDER 24 HRS. <b>2</b> Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Home Work</b>		11. BIRTHPLACE (State or foreign country) <b>Canada</b>	
12. CITIZEN OF WHAT COUNTRY? <b>United States</b>							
13. FATHER'S NAME <b>Smith</b>				14. MOTHER'S MAIDEN NAME <b>Irene Etter</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>(If yes, give war or dates of service)</b>				16. SOCIAL SECURITY NO. <b>INFORMANT</b>			
17. Address <b>2-Cedar Ave</b>				18. Informant <b>Roy M. Smith. Shankle. Gaithersburg. Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Years.</b> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>Nov. 1960</b> to <b>Feb. 15, 1961</b> , that I last saw the deceased alive on <b>Feb. 15, 1961</b> , and that death occurred at <b>10:50 A.M.</b> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <b>105 Russell Ave., Gaithersburg, Md.</b>				DATE SIGNED <b>2-16-61</b>			
ACTUAL SIGNATURE <b>Jack Schumacher</b>							
PHYSICIAN'S NAME (Type) <b>Jack Schumacher</b>							
22a. BURIAL, CREMATION, REMOVAL (Type) <b>Burial</b>		22b. DATE THEREOF <b>2-17-61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>ParkLawn</b>		22d. LOCATION (City, town, or county) (State) <b>Rockville. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ernest C. Gartner. Gaithersburg. Md.</b>				24a. REC'D BY REGISTRAR <b>DATE FEB 20 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>	

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TO HOSPITAL OR FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed on 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

02137

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Arlington</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY IN 1b <b>17 hrs.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>U. S. Naval Hospital</b>		d. STREET ADDRESS <b>1415 S. Edgewood - Apt. 464</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Kevin Creighton SIMPSON</b>		4. DATE OF DEATH Month Day Year <b>February 21 1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-21-61</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -----		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13. FATHER'S NAME <b>Ottis J. SIMPSON</b>		14. MOTHER'S MAIDEN NAME <b>Mary E. PARKER</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>(F) O.J. Simpson, same as #2 above</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>APNEA NEONATORUM</b> 762-5 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>POST MATURITY</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Feb. 21 7:45 PM</b> to <b>Feb. 21 1961</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Feb. 21 1961</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Fred W. Grello</b>		22b. DATE SIGNED <b>2-22-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Fred W. GRELLO, LT, MC USN</b>		22d. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2-24-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		23d. LOCATION (City, town or county) (State) <b>Arlington Virginia</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Murphy Funeral Home, 3524 Columbia Pike, Arlington Va.</b>		25a. REC'D BY REGISTRAR <b>FEB 27 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>			

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0111

Wilmington

Wilmington

Wilmington - 1911

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Page 4  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2161

CERTIFICATE OF DEATH

02138

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b> c. LENGTH OF STAY IN lb <b>31 HRS.</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MONTGOMERY GENERAL HOSPITAL</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>GAITHERSBURG</b> d. STREET ADDRESS <b>211 LEE STREET</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <b>LLOYD RONALD SMITH, JR.</b>			4. DATE OF DEATH Month Day Year <b>FEBRUARY 24 19 61</b>		
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>2/22/61</b>		9. AGE (In years last birthday) <b>13</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min. <b>13</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>					
13. FATHER'S NAME <b>LLOYD RONALD SMITH</b>			14. MOTHER'S MAIDEN NAME <b>MARGARET MAE BART</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>HOSPITAL RECORDS, OLNEY, MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Atelectasis</b> 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <b>Immaturity + Prematurity</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>HOURS</b>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>GAITHERSBURG, MARYLAND</b>		20g. (County) <b>Redland</b>		20h. (State) <b>Montgomery, Md.</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>Feb. 22, 1961</b> to <b>Feb. 24, 1961</b> , that (I) (we) last saw the deceased alive on <b>Feb. 23, 1961</b> , and that death occurred at <b>4:45 AM</b> , from the causes and on the date stated above.					
22a. SIGNATURE <b>Dr. J. Schumacher, M. D.</b>		22b. DATE <b>2-24-61</b>		22c. PHYSICIAN'S NAME (Type) <b>DR. J. SCHUMACHER, M. D.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2-25-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Flower Hill</b>	
23d. LOCATION (City, town, or county) <b>Redland</b>		23e. (State) <b>Montgomery, Md.</b>		23f. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Francis H. Barber</b>		24a. ADDRESS <b>Laytonsville, Md.</b>		24b. DATE <b>FEB 28 '61</b>	

2073202XV1

2161

MONTGOMERY

LEWIS

31 DEC.

MONTGOMERY GENERAL HOSPITAL

LEWIS

RONALD

3-22-61

WHITE

MONTGOMERY

LEWIS RONALD SMITH

MONTGOMERY MAR 5 1961

HOSPITAL RECORDS

CLERK, JR.

R. J. SCHUMACHER, M. D.

MONTGOMERY, ALABAMA

2-2-61

MONTGOMERY

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

2162

02139

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park, Md</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hyattsville, Md.</u>			
c. LENGTH OF STAY IN 1b <u>10 days</u>				d. STREET ADDRESS <u>2015 Woodberry St.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Grace Mae Spangenberg</u>				4. DATE OF DEATH Month Day Year <u>Feb 20 1961</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/7/89</u>	9. AGE (In years last birthday) <u>71</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Penna.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Kimble</u>				14. MOTHER'S MAIDEN NAME <u>DeLong</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>Harold Spangenberg (same as #2)</u>			
17. INFORMANT <u>Harold Spangenberg (same as #2)</u>				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>Coronary Arteriosclerosis with</u> <u>Myocardial Infarction</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2/10/61</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) <u>6/24/43</u> <u>43</u> <u>2/20/61</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>6/24/43</u> to <u>2/20/61</u> , that (I) (we) last saw the deceased alive on <u>2/20/61</u> , and that death occurred at <u>10:15</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Howard T Morse</u>				22b. DATE SIGNED <u>2/20/61</u>			
22c. PHYSICIAN'S NAME (Type) <u>Howard T Morse</u>				22d. ADDRESS <u>7030 Carroll Ave Takoma Park Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/23/1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lakewood Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Lakewood, Pa.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Nelson</u>				25a. REC'D BY REGISTRAR DATE <u>FEB 23 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed in 24 hours after death. Pages 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

(M)

(I)

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2163

**CERTIFICATE OF DEATH**

02140

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>15 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Rhode Island</b> b. COUNTY <b>Newport</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>86 Rhode Island Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Margaret Ramsay STAPLER</b>			4. DATE OF DEATH Month <b>February</b> Day <b>4</b> Year <b>1961</b>				
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-17-82</b>	9. AGE (In years last birthday) <b>78 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>- - - -</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>			
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Henry RAMSAY</b>			14. MOTHER'S MAIDEN NAME <b>Julia COOKE</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>(H) John T.G. Stapler, same as #2 above</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> <b>527.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Pulmonary Embolism</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>Swiss</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>1961</b>	(County) (State)			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Jan. 20</b> <b>1961</b> to <b>Feb. 4</b> <b>1961</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Feb. 4</b> <b>1961</b> , and that death occurred at <b>2:10AM</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>William P. Baker</b>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>2-4-61</b>			
22c. PHYSICIAN'S NAME (Type) <b>William P. BAKER, LT, MC, USN</b>		22d. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>2-7-61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>	23d. LOCATION (City, town, or county) (State) <b>Arlington Virginia</b>				
24. FUNERAL DIRECTOR'S SIGNATURE <b>Jos. Gawlers' Sons</b>		ADDRESS <b>Jos. Gawlers' Sons, 1756 Penn. Ave., NW, WashDC</b>		25a. REC'D BY REGISTRAR <b>FEB 7 '61</b>	25b. REGISTRAR'S SIGNATURE <b>Carl S. Kraus</b>		

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

2113

CERTIFICATE OF DEATH

1913

Name of Deceased

Sex ( )

Age

Place of Birth

Occupation

Residence

Marital Status

Signature of Registrar

14

1913

1913

U.S. DEPARTMENT OF HEALTH

2-1-13

Washington, D.C.

1913

U.S. DEPARTMENT OF HEALTH



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

216 MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02141

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>			
c. LENGTH OF STAY in 1b <b>32 mo.</b>				d. STREET ADDRESS <b>5721 Grosvenor Lane, Bethesda</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Resmor Sanitarium and Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Virginia Belle Staub</b>				4. DATE OF DEATH Month Day Year <b>February 19 19 61</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>22 January 1889</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) <b>72 yrs.</b>		11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>	
13. FATHER'S NAME <b>Richard S. Gaskins</b>				14. MOTHER'S MAIDEN NAME <b>Minnick</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Wm. H. Gaskins</b>		Address <b>Edgewater, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO (b) <b>Hypertension &amp; Cardiovascular disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Amputation of left leg in 1958 following a fracture</b>				INTERVAL BETWEEN ONSET AND DEATH <b>Found dead in bed 2 yrs</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Frank J. Broschert</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>FRANK J. Broschert</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>Feb 19-61</b>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/21/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Oak Hill Cemetery</b>		22d. LOCATION (City, town, or country) (State) <b>Washington, D. C.</b>	
23. FUNERAL DIRECTOR <b>Joseph F. Birch's Sons</b>				ADDRESS <b>Wash, D.C.</b>			
24a. REC'D BY REGISTRAR <b>FEB 23 '61</b>				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>			

MEDICAL CERTIFICATION

1940  
1941

1

Page 4  
TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
ISM 9/59

MARYLAND STATE BOARD OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
2165  
CERTIFICATE OF DEATH

02142

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Wheaton Nursing Home, Wheaton, Md</b> c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>Washington D.C. Maryland</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Wheaton Nursing Home</b>		d. STREET ADDRESS <b>2122 California St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Orithia Josepline Steenis</b>		4. DATE OF DEATH Month <b>Feb.</b> Day <b>18</b> Year <b>1961</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 24, 1872</b>
9. AGE (In years last birthday) <b>88</b> yrs.		10. IF UNDER 1 YEAR Months <b>88</b> Days <b>88</b> Hours <b>88</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>ALTON, ILLINOIS</b> <b>New York, New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>Am.</b>	
13. FATHER'S NAME <b>Spencer Halt</b>		14. MOTHER'S MAIDEN NAME <b>ORENTHIA Clark</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>unknown</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Nursing Home records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b> DUE TO <b>Myocarditis, Chronic</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic heart disease</b> (c) <b>4-5 yrs</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4-5 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Old age &amp; debility</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>June 1956</b> to <b>Feb 18 1961</b> , that (I) (we) last saw the deceased alive on <b>Jan 15 1961</b> , and that death occurred at <b>10 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Oliver E. Thompson</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Oliver E. Thompson</b>		22d. ADDRESS <b>901 Pershing Dr., Silver Spring, Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>2/20/1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Greenwood Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Rockford, Illinois</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Jos. Lawrence</b>		25a. REC'D BY REGISTRAR <b>DATE FEB 20 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. House</b>			

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1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

## 2166

02143

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Washington, D. C.</b>		b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY IN 1b <b>1 day</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington, 10</b>		d. STREET ADDRESS <b>A713 The Woodner</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>David</b>		First <b>David</b>		Middle <b>Darrin</b>		Last <b>STEINBERG</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Caucasian</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12-17-56</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>- - - - -</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>- - - - -</b>		11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Harvey STEINBERG</b>				14. MOTHER'S MAIDEN NAME <b>Annette WALLACE</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Neuroblastoma, disseminated</b> <b>193.4</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <b>8 months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. _____ p. m. _____ Month, Day, Year _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (1) (this hospital) attended the deceased from <b>Feb. 13</b> , 19 <b>61</b> , to <b>Feb. 14</b> , 19 <b>61</b> , that (2) (we) last saw the deceased alive on <b>Feb. 14</b> , 19 <b>61</b> , and that death occurred at <b>12PM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Robert V. Rack</b>		M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>2-15-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Robert V. RACK, LT, MC, USN</b>				22d. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2-17-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		23d. LOCATION (City, town, or county) (State) <b>Arlington Virginia</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Simmons Bros.</b>		ADDRESS <b>WashDC</b>		25a. REC'D BY REGISTRAR <b>DATE FEB 17 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>	

1966

STATE OF DEATH

1966

Washington, D.C.

Montgomery

Washington, D.C.

Barney (Barry)

Washington, D.C.

U.S. Navy Hospital

Washington, D.C.

Naval

2-17-66

Washington

Male

Washington, D.C.

U.S. Navy Hospital

Washington, D.C.

U.S. Navy Hospital

U.S. Navy

Male

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Feb. 17, 1966

Feb. 17, 1966

1966

U.S. Navy Hospital, Washington, D.C.

U.S. Navy Hospital, Washington, D.C.

Washington, D.C.

Washington, D.C.

U.S. Navy Hospital

U.S. Navy

Male

U.S. Navy

U.S. Navy Hospital, Washington, D.C.



Page 4  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

02144

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>4529 Windsor Lane</b>				d. STREET ADDRESS <b>4529 Windsor Lane</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>Oscar J. Stephens</b>				4. DATE OF DEATH Month <b>February</b> Day <b>19</b> Year <b>19 61</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 24, 1885</b>	
9. AGE (In years last birthday) <b>75</b> yrs.		10. IF UNDER 1 YEAR Months <b>8</b> Days <b>25</b>		11. IF UNDER 24 HRS. Hours <b>25</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Gov't</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Oscar J. Stephens</b>				14. MOTHER'S MAIDEN NAME <b>Catherine Lowe</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Eudora Stephens-Wife-same 2d</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ventricular fibrillation</b> DUE TO <b>420.0</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>coronary occlusion</b> DUE TO (c) <b>arteriosclerotic heart disease</b>				INTERVAL BETWEEN ONSET AND DEATH <b>5 min</b> <b>15 min</b> <b>5 years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>January 12, 1961</b> to <b>February 12, 1961</b> , that (I) (we) last saw the deceased alive on <b>Feb 12, 1961</b> , and that death occurred on <b>Feb 12, 1961</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Thomas F. O'Connor</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>THOMAS F. O'CONNOR</b>				22d. ADDRESS <b>4861 BATTERY LANE BETHESDA 14, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/22/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>All Sts. Church Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>Oakley, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>				ADDRESS <b>Bethesda, Maryland</b>		25a. REC'D BY REGISTRAR DATE <b>FEB 21 '61</b>	
						25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

STATE OF NEW YORK

1816

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Page 4  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FAIRLAND</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring, Md.</b>	
c. LENGTH OF STAY IN 1b <b>6/30/60-2/16/61</b>		d. STREET ADDRESS <b>14428 Colesville Rd.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>FAIRLAND-NURSING Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ELLEN</b> First <b>C</b> Middle <b>STEWART</b> Last		4. DATE OF DEATH Month <b>2-</b> Day <b>16</b> Year <b>1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept 26-1888</b>
9. AGE (In years last birthday) <b>75</b> yrs.		IF UNDER 1 YEAR: Months <b>1</b> Days <b>16</b> Hours <b>15</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CLERK</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>GOVERNMENT</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington DC</b>		12. CITIZEN OF WHAT COUNTRY? <b>U-S A</b>	
13. FATHER'S NAME <b>Joseph Henry CROWN</b>		14. MOTHER'S MAIDEN NAME <b>MARY FRANCES GRUBB</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>Miss RACHEL CROWN</b>		Address <b>14,428 Colesville Rd.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO <b>Arteriosclerotic Heart Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive Cardiovascular Disease</b> DUE TO (c) <b>5mm.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5mm.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>5b</b> to <b>2/16</b> <b>1961</b> , that (I) (we) last saw the deceased alive on <b>also</b> <b>61</b> , and that death occurred at <b>11:30 A</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>C.H. Higgin</b>		22b. DATE SIGNED <b>2/16/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>C.H. Higgin</b>		22d. ADDRESS <b>Sandy Spring, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>2/20/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>ROCK CREEK CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>WASHINGTON, D.C.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond E. Pumphrey, Inc.</b>		ADDRESS <b>SILVER SPRING, MD.</b>	
25a. REC'D BY REGISTRAR <b>FEB 23 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Fennell</b>	

STATE OF TEXAS

1888

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TO HOSPITAL OR FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR FUNERAL DIRECTOR: This law requires that the death certificate be executed within 24 hours after death. Pages 3 and 4 may be retained by the hospital or after-discharge physician.

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
2169													
02146													
CERTIFICATE OF DEATH													
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>9 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium &amp; Hospital</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>35 Kensington</u> d. STREET ADDRESS <u>111203 Landy Court</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Isabel</u> Middle <u>Mackey</u> Last <u>Suto</u>						4. DATE OF DEATH Month <u>February</u> Day <u>24</u> Year <u>1961</u>							
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Cauc.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-24-19</u>		9. AGE (In years last birthday) <u>41</u> yrs.		IF UNDER 1 YEAR Months <u>4</u> Days <u>1</u> Hours <u>1</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife &amp; R.N.</u>						10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>William S. Parkins</u>						14. MOTHER'S MAIDEN NAME <u>Mattie Sterrett</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WW2</u>						16. SOCIAL SECURITY NO. <u>- - - - -</u>						17. INFORMANT Address <u>Husband - Mr. Frank Suto - same as above</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)													
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Toxemia, septicemia</u> <u>153.3</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>general peritonitis</u> DUE TO (c) <u>perforated abscessed cancer sigmoid</u>												INTERVAL BETWEEN ONSET AND DEATH <u>1 wh</u> <u>1 wh</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>laparotomy, resection of recto sigmoid</u>												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>2-15-61</u> , 19 <u>61</u> , to <u>2-24-61</u> , that (I) (we) last saw the deceased alive on <u>2-24</u> , 19 <u>61</u> , and that death occurred at <u>10 P.M.</u> from the causes and on the date stated above.													
22a. SIGNATURE <u>John O. Robben MD</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>2-24-61</u>					
22c. PHYSICIAN'S NAME (Type) <u>John O. Robben</u>						22d. ADDRESS <u>1015 Spring Silver Spring Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>2-28-1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l. Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Arlington, Va.</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Hawley's Sons</u>						25a. REC'D BY REGISTRAR <u>1756 Pa. Ave. N.W.</u>		25b. REGISTRAR'S SIGNATURE <u>Washington D.C.</u>		DATE <u>FEB 28 '61</u>			



2159

Mr. [illegible]

Dear Sir,

9 days

Washington, D.C.

Truly

Yours

Sincerely

1900-1901

Respectfully

William S. [illegible]

Miss [illegible]

Very

Respectfully

Yours

Truly

Respectfully

Yours

Truly

Respectfully

Yours

Truly

Respectfully

Yours

Truly

Respectfully

Yours



TO HOSPITAL OR FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

1

Dr. Broschart (Med. Examiner) notified - approved - signed a true & correct copy of the death certificate for the funeral home.

MEDICAL CERTIFICATION

MAYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MAYLAND													
CERTIFICATE OF DEATH													
2170													
02147													
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Washington</u> b. COUNTY <u>DC</u>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>						c. LENGTH OF STAY IN 1b <u>D.O.A.</u>							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. San &amp; Hosp</u>						d. STREET ADDRESS <u>5606 Broad Branch Rd NW.</u>							
3. NAME OF DECEASED (Type or print) First <u>Rose</u> Middle <u>-</u> Last <u>Sverdlhoff</u>						4. DATE OF DEATH Month <u>2</u> Day <u>26</u> Year <u>1961</u>							
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-5-88</u>		9. AGE (In years last birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR Months <u>72</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hwf.</u>						10b. KIND OF BUSINESS OR INDUSTRY							
11. BIRTHPLACE (County & State, or foreign country) <u>Russia</u>						12. CITIZEN OF WHAT COUNTRY? <u>Russia</u>							
13. FATHER'S NAME <u>Jacob Bondareff</u>						14. MOTHER'S MAIDEN NAME <u>Sonia Fine</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>						16. SOCIAL SECURITY NO. <u>17-18-9744</u>							
17. INFORMANT <u>Mrs. Charlotte Wolfson</u> Address <u>Same as deceased</u>													
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute cardiac fibrillation</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>chronic myocarditis &amp; Lt bundle br. block</u> (c) <u>443X</u> DUE TO (e), stating the underlying cause last.												INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Hypertension</u> <u>Arteriosclerosis</u>													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Nov 12</u> , 19 <u>60</u> , to <u>2.7</u> , 19 <u>61</u> ; that (I) (we) last saw the deceased alive on <u>2.7</u> , 19 <u>61</u> , and that death occurred at <u>8:15</u> P.M. from the causes and on the date stated above.													
22a. SIGNATURE <u>Stanley Paul Porton</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>2.26.61</u>							
22c. PHYSICIAN'S NAME (Type) <u>Stanley Paul Porton</u>						22d. ADDRESS <u>300 - Hamilton St. N.W.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>2/28/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>BETH SHOLOM CEM</u>		23d. LOCATION (City, town or county) <u>CAP. HTS. MD.</u> (State)							
24. FUNERAL DIRECTOR'S SIGNATURE <u>Goldberg</u> ADDRESS <u>4217-9 1st St N.W.</u>						25a. REC'D BY REGISTRAR <u>DATE MAR 2 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>					

2170

Washington, D.C.

Dear Sir,  
I have the honor to acknowledge the receipt of your letter of the 10th inst.

and in reply to inform you that the same has been forwarded to the proper authorities for their consideration.

I am, Sir, very respectfully,  
Your obedient servant,

Wm. H. Rouse

Very truly yours,

Wm. H. Rouse  
Secretary  
U. S. Fish Commission  
Washington, D. C.

Page 4  
TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
2171  
CERTIFICATE OF DEATH  
02148

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>18 1/2 hrs.</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>cecil</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perryville</b> d. STREET ADDRESS <b>S&amp;S Bldg., General Delivery</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Victor</b> First <b>Michael</b> Middle <b>SZACIK</b> Last		4. DATE OF DEATH Month <b>February</b> Day <b>8</b> Year <b>19 61</b>					
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-7-61</b>	9. AGE (In years lost birthday) yrs. <b>18</b>	IF UNDER 1 YEAR Months <b>18</b> Days <b>34</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>			
13. FATHER'S NAME <b>Mitchell S. SZACIK</b>			14. MOTHER'S MAIDEN NAME <b>Nora Frances BLUME</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Hospital Records</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>769.6</b> DUE TO <b>prematurity.</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>maternal diabetes; cesarean section.</b>				INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Feb. 7, 19 61 to Feb. 8, 19 61</b> <b>9:35 AM</b>			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Feb. 7, 19 61</b> to <b>Feb. 8, 19 61</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Feb. 8, 19 61</b> , and that death occurred at <b>M.</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Robert V. Rack</b>		22b. DATE SIGNED <b>2-8-61</b>		22c. PHYSICIAN'S NAME (Type) <b>Robert V. Rack, LT, MC, USN</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2-10-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>R. A. Pumphrey</b>		25a. REC'D BY REGISTRAR <b>DATE FEB 10 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

2051181XVI

CERTIFICATE OF DEATH

1911

NAME OF DECEASED  
AGE  
SEX  
RACE  
DATE OF BIRTH  
PLACE OF BIRTH  
DATE OF DEATH  
PLACE OF DEATH  
CAUSE OF DEATH  
MANNER OF DEATH  
SIGNATURE OF PHYSICIAN  
SIGNATURE OF WITNESSES  
SIGNATURE OF DECEASED

NAME OF DECEASED  
AGE  
SEX  
RACE  
DATE OF BIRTH  
PLACE OF BIRTH  
DATE OF DEATH  
PLACE OF DEATH  
CAUSE OF DEATH  
MANNER OF DEATH  
SIGNATURE OF PHYSICIAN  
SIGNATURE OF WITNESSES  
SIGNATURE OF DECEASED

NAME OF DECEASED  
AGE  
SEX  
RACE  
DATE OF BIRTH  
PLACE OF BIRTH  
DATE OF DEATH  
PLACE OF DEATH  
CAUSE OF DEATH  
MANNER OF DEATH  
SIGNATURE OF PHYSICIAN  
SIGNATURE OF WITNESSES  
SIGNATURE OF DECEASED



5175

*[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page]*

MADE IN U.S.A.



TO HOSPITAL OR DURING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/60

1

2173

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

02150

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>31/10"</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> d. STREET ADDRESS <u>Queen Pl. Alpine Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Baby</u> First <u>Boy</u> Middle <u>Thomas</u> Last <u>Thomas</u> 4. DATE OF DEATH <u>Feb 22</u> Month <u>Feb</u> Day <u>22</u> Year <u>1961</u>		9. AGE (In years last birthday) <u>3</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. <u>3</u> <u>10</u>	
5. SEX <u>M</u> 6. COLOR OR RACE <u>C</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>Feb 22 1961</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>Willigins</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u></u> 10b. KIND OF BUSINESS OR INDUSTRY <u></u>		13. FATHER'S NAME <u>Joseph B. Thomas</u> 14. MOTHER'S MAIDEN NAME <u>William</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u></u> 16. SOCIAL SECURITY NO. <u></u> 17. INFORMANT <u>William Thomas</u> Address <u></u>		18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>776X</u> DUE TO <u>Permativity</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO <u></u> (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u></u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year <u>19</u> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u> 20f. (City or town) (County) (State) <u></u>		21. I certify that (I) (this hospital) attended the deceased from <u>2/22</u> , 19 <u>61</u> , to <u>2/22</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>2/22</u> , 19 <u>61</u> , and that death occurred <u>AT HOME</u> from the causes and on the date stated above.	
22a. SIGNATURE <u>Robert L. Snowden</u> M.D. 22b. DATE SIGNED <u>2/24/61</u> 22c. PHYSICIAN'S NAME (Type) <u></u> 22d. ADDRESS <u></u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>2/26/61</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Park.</u> 23d. LOCATION (City, town or county) (State) <u>Rockville, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Snowden</u> ADDRESS <u>Rockville, Md.</u> 25a. REC'D BY REGISTRAR <u>MAR 2 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur L. House</u>			

3074289XV0

5128

Handwritten notes, possibly a list or index, with some entries circled. The text is faint and difficult to decipher, but appears to include names and dates.

Handwritten notes, possibly a list or index, with some entries circled. The text is faint and difficult to decipher, but appears to include names and dates.

Page 4  
TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

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2174  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
02151

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>42 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brandywine</b> d. STREET ADDRESS <b>Rt. 2, Box 45</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Joseph</b> Middle <b>Anderson</b> Last <b>THOMAS</b>		4. DATE OF DEATH Month <b>February</b> Day <b>10</b> Year <b>19 61</b>							
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-21-01</b>	9. AGE (In years last birthday) <b>59</b> yrs.	IF UNDER 1 YEAR Months <b>59</b>	IF UNDER 24 HRS. Days <b>59</b>	Hours <b>59</b>	Min. <b>59</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>		11. BIRTHPLACE (State or foreign country) <b>Georgia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Joseph A. THOMAS</b>		14. MOTHER'S MAIDEN NAME <b>Blanche WILSON</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WWI</b>		17. INFORMANT <b>(W) Mrs. Louise Thomas, same as #2 above</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchiogenic carcinoma with metatases</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>162.1</b> (c) <b>162.1</b> DUE TO (b) <b>162.1</b> (c) <b>162.1</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6-7 mos.</b>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Dec. 30 1961</b> to <b>Feb. 10 1961</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Feb. 10 1961</b> , and that death occurred at <b>12:20PM</b> , from the causes and on the date stated above.		22a. SIGNATURE <b>F. M. Highley, Jr.</b> M.D.		22b. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b>		22c. PHYSICIAN'S NAME (Type) <b>F. M. HIGHLEY, JR., LT, MC, USN</b>		22d. DATE <b>2-10-61</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/15/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington</b>		23d. LOCATION (City, town, or county) (State) <b>Arlington Va.</b>		25a. REC'D BY REGISTRAR <b>W. W. Chambers</b> DATE <b>FEB 14 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>W. W. Chambers</b>		25c. REGISTRAR'S SIGNATURE <b>W. W. Chambers</b>		25d. REGISTRAR'S SIGNATURE <b>W. W. Chambers</b>		25e. REGISTRAR'S SIGNATURE <b>W. W. Chambers</b>		25f. REGISTRAR'S SIGNATURE <b>W. W. Chambers</b>	

(2.10)  $\mathcal{A} = \mathcal{A}_1 \oplus \mathcal{A}_2$ .

1997

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2175

## CERTIFICATE OF DEATH

02152

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>District of Columbia</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>				c. LENGTH OF STAY IN 1b <b>82 days</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>U. S. Naval Hospital</b>				e. STREET ADDRESS <b>1776 Pennsylvania Ave., N.W.</b>			
<b>3. NAME OF DECEASED</b> (Type or print) <b>Clary</b>				<b>4. DATE OF DEATH</b> Month Day Year <b>February 26 19 61</b>			
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>Caucasian</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>9-30-12</b>	
<b>9a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Foreign Service Officer U. S. Govt.</b>				<b>9b. KIND OF BUSINESS OR INDUSTRY</b> <b>North Carolina</b>		<b>9. AGE</b> (In years last birthday) <b>48 yrs.</b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Foreign Service Officer U. S. Govt.</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>North Carolina</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>USA</b>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>				<b>13. FATHER'S NAME</b> <b>Edward B. THOMPSON</b>			
<b>14. MOTHER'S MAIDEN NAME</b> <b>Newell MC DUFFLE</b>				<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes 1942 to 1946</b>			
<b>16. SOCIAL SECURITY NO.</b> <b>(W) Mrs. Jessie Thompson, same as #2 above</b>				<b>17. INFORMANT</b> Address <b>(W) Mrs. Jessie Thompson, same as #2 above</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>metastatic Carcinoma</b> DUE TO (b) <b>Carcinoma, stomach</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>3 yrs.</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour e.m. p.m. <b>19</b>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)				<b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that</b> <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Dec. 6 1960</b> to <b>Feb. 26 1961</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Feb. 26 1961</b> , and that death occurred at <b>4:35 PM</b> , from the causes and on the date stated above.							
<b>22a. SIGNATURE</b> <b>F. H. O'Connell</b>				<b>22b. DATE SIGNED</b> <b>2-27-61</b>			
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>F. H. O'CONNELL, LCDR, MC, USN</b>				<b>22d. ADDRESS</b> <b>U. S. Naval Hospital, Bethesda, Md.</b>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>cremation</b>		<b>23b. DATE THEREOF</b> <b>2-28-61</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Cedar Hills Crematory</b>		<b>23d. LOCATION</b> (City, town or county) (State) <b>Suitland Maryland</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Jos. Gawler's Sons Funeral Home, 1756 Pa. Ave., N.W.</b>				<b>25a. REC'D BY REGISTRAR</b> <b>MAR 1 '61</b>			
<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Kraus</b>							

TO HOSPITAL OR FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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02155

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>		c. LENGTH OF STAY IN 1b <b>4 yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1006 STROUT STREET</b>		d. STREET ADDRESS <b>1006 STROUT STREET</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>EMMETT FRANKLIN THOMPSON</b>		4. DATE OF DEATH Month <b>FEB.</b> Day <b>9</b> Year <b>19 61</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>10/23/95</b>		9. AGE (In years last birthday) <b>65</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Building, Chief Engineer</b>		12. KIND OF BUSINESS OR INDUSTRY <b>I.B.E.W.</b>		13. BIRTHPLACE (State or foreign country) <b>WASHINGTON, D.C.</b>	
14. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		15. FATHER'S NAME <b>JOHN THOMPSON</b>		16. MOTHER'S MAIDEN NAME <b>MARY JANE MULLIN</b>	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		18. SOCIAL SECURITY NO. <b>578-03-9747</b>		19. INFORMANT Address <b>Mrs. Catherine C. Thompson, 1006 Strout St.</b>	
20. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>422.2</b> IMMEDIATE CAUSE (a) <b>Chronic Myocarditis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Diabetes Mellitus</b> DUE TO (c)		21. INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs.</b>			
22. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes Mellitus</b>		23. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
24a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		24b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
25a. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <b>19</b>		25b. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		25c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>3524 Old Mt. Road, Silver Spring, Md.</b>	
25d. (City or town) <b>SILVER SPRING</b>		25e. (County) <b>MONTGOMERY</b>		25f. (State) <b>MARYLAND</b>	
26. I certify that (I) (this hospital) attended the deceased from <b>Feb. 1, 1961</b> to <b>Feb. 9, 1961</b> , that (I) (we) last saw the deceased alive on <b>Feb. 9, 1961</b> , and that death occurred at <b>1006 Strout St.</b> M, from the causes and on the date stated above.		27a. SIGNATURE <b>J. Chester Brady</b>		27b. DATE SIGNED <b>Feb 11/61</b>	
27c. PHYSICIAN'S NAME (Type) <b>J. CHESTER BRADY</b>		27d. ADDRESS <b>3524 Old Mt. Road, Silver Spring, Md.</b>			
28a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		28b. DATE THEREOF <b>2/13/61</b>		28c. NAME OF CEMETERY OR CREMATORY <b>GATE OF HEAVEN CEMETERY</b>	
28d. LOCATION (City, town, or county) <b>MONTGOMERY COUNTY, MARYLAND</b>		28e. (State) <b>MARYLAND</b>			
29. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond A. Biska</b>		29a. ADDRESS <b>SILVER SPRING, MD.</b>		29b. REC'D BY REGISTRAR <b>FEB 15 '61</b>	
29c. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>		29d. (City, town, or county) <b>SILVER SPRING, MD.</b>		29e. (State) <b>MARYLAND</b>	

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1958

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2177

## CERTIFICATE OF DEATH

Reg. Dist. No. 12154

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> 59	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>8306 Woodhaven Blvd.</b>		d. STREET ADDRESS <b>8306 Woodhaven Blvd.</b>	
3. NAME OF DECEASED (Type or print) <b>HARRY THOMAS THOMPSON</b>		4. DATE OF DEATH Month <b>2</b> Day <b>25</b> Year <b>1961</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>FEB 29 1908</b>
9. AGE (In years last birthday) <b>62</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PARK-SDPT</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Gov't.</b>	
11. BIRTHPLACE (State or foreign country) <b>Penn.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13. FATHER'S NAME <b>LaFayette</b>		14. MOTHER'S MAIDEN NAME <b>STOCKDALE</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>(Wife) ISABELLA MURRAY THOMPSON</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MALIGNANT CACITEXIA</b> <b>151X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CARCINOMATOSIS, LIVER, PERITONEUM</b> DUE TO (c) <b>CARCINOMA, STOMACH</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 MONTHS</b> <b>3 MONTHS</b> <b>1 YEAR</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>MAY 19 1956</b> to <b>FEBRUARY 25 1961</b> , that I last saw the deceased alive on <b>FEB 26 1961</b> , and that death occurred at <b>7:20 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Robert L. Angle</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>5009 Del Ray Ave Bethesda, Md. 2/25/61</b>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation 2-27-1961</b>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>		22d. LOCATION (City, town, or county) (State) <b>Suitland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph J. Andrews, Inc. 1756 Pa Ave NW</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 28 '61</b>	
		24b. REGISTRAR'S SIGNATURE <b>Carlton L. Knecht</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be related to the death of the deceased by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

5515

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MONTGOMERY  
090  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
02155

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brooke Grove Foundina</u> c. LENGTH OF STAY IN 1b <u>1 yr 1 mo</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Olney</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>✓</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arlington</u> d. STREET ADDRESS <u>5212 Little Falls Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Mabel E. Torrey</u> First Middle Last 4. DATE OF DEATH <u>Feb 7 1961</u> Month Day Year				5. SEX <u>Female</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>Feb 16, 1874</u> 9. AGE (In years lost birthday) <u>86</u> yrs. 10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maine</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Lyman K. Gardner</u>				14. MOTHER'S MAIDEN NAME <u>Mary Hobart</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Edwin L. Kirby SR 5235</u> Address <u>Arlington Blvd. Arlington, Va.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute cellulitis left foot</u> 350X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Serious circulatory &amp; venous disease &amp; CVA</u> 4 Mo DUE TO (c) <u>Poor influence of Parkinson's disease</u> 18 yrs INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 8, 1960</u> to <u>7 Feb 1961</u> , that (I) (we) last saw the deceased alive on <u>2 Feb 1961</u> , and that death occurred at <u>2:15 PM</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>John B. Ziegler</u>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>JOHN B. ZIEGLER</u>				22d. ADDRESS <u>OLNEY MD</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)			
<u>cremation</u>		<u>2/9/61</u>		<u>Ft. Lincoln Crematory</u>		<u>Prince Georges, Md.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Company</u>				ADDRESS <u>2901 14th St. N.W. Washington 9, D.C.</u>		25a. REC'D BY REGISTRAR <u>DATE FEB 10 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. K...</u>	





Page 4  
TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02156

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>4 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> d. STREET ADDRESS <b>9212 Bardon Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Herman</b> Middle <b>(None)</b> Last <b>Tuckman</b>		4. DATE OF DEATH Month <b>February</b> Day <b>17</b> Year <b>19 61</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 20, 1901</b>
9. AGE (In years last birthday) yrs. <b>59</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Builder</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>	
11. BIRTHPLACE (State or foreign country) <b>Poland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Harry Tuckman</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Wolman</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>579-40-1944</b>	
17. INFORMANT <b>The Medical Record</b>		Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Septicemia Gram and Organism</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Carcinoma of Colon, Metastasis to liver and lungs</b> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>48 Hours</b> <b>8 Hours</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>February 13 19 61</b> to <b>February 17 19 61</b> , that (I) (we) last saw the deceased alive on <b>Feb. 17 19 61</b> , and that death occurred on <b>2:15 PM</b> from the causes and on the date stated above.			
22a. SIGNATURE <i>Walter Opelt</i>		22b. DATE SIGNED <b>2/17/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Walter Opelt M.D.</b>		22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/19/1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>MT. Lebanon Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>Hyattsville, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>B. Danzansky Sons</b>		25a. REC'D BY REGISTRAR <b>WASH. D.C.</b>	
25b. REGISTRAR'S SIGNATURE <i>Quinton L. Kenna</i>		DATE <b>FEB 21 '61</b>	

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Page 4  
TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

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DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

2180

02157

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park,</b> c. LENGTH OF STAY IN 1b <b>Washington Sanitarium and Hospital</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington Sanitarium and Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>35 Silver Spring,</b> d. STREET ADDRESS <b>14046 Adams Drive,</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Warrell</b>		4. DATE OF DEATH Month <b>February</b> Day <b>25</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 24, 1961</b>
9. AGE (In years last birthday) <b>6</b> yrs.		10. IF UNDER 1 YEAR Months <b>6</b> Days <b>55</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>6 1/2 hrs.</b>	
13. FATHER'S NAME <b>Carroll</b>		14. MOTHER'S MAIDEN NAME <b>Gene Warrell</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>	
17. INFORMANT <b>father</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Prematurity</b> DUE TO <b>776X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>no</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
21. I certify that <b>(I)</b> (this hospital) attended the deceased from <b>2/24</b> 19 <b>61</b> to <b>2/25</b> 19 <b>61</b> , that <b>(I)</b> (we) last saw the deceased alive on <b>2/24</b> 19 <b>61</b> , and that death occurred at <b>2:45</b> AM, from the causes and on the date stated above.		22. SIGNATURE <b>James R. Coleman M.D.</b> M.D. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. ADDRESS <b>733 Sligo Ave., Silver Spring, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE THEREOF <b>2-26-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Washington Sanitarium &amp; Hospital, Takoma Park, Maryland</b>		23d. LOCATION (City, town, or county) (State) <b>Washington Sanitarium &amp; Hospital, Takoma Park, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Hare, M. D. Washington San. &amp; Hospital</b>		25a. REC'D BY REGISTRAR <b>FEB 28 '61</b> DATE <b>Arthur S. Hare</b>	

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CERTIFICATE OF DEATH

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**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

**CERTIFICATE OF DEATH**

2181

02158

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fairland (Rural)</b>			c. LENGTH OF STAY IN lb <b>6 years</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fairland (Rural)</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <b>1</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ALBURN</b> Middle <b>H.</b> Last <b>WATKINS</b>		4. DATE OF DEATH Month <b>Feb.</b> Day <b>2</b> Year <b>19 61</b>					
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 6, 1861</b>		9. AGE (In years lost birthday) yrs. <b>99</b>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired-Guard</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Gov't</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Joshua Watkins</b>				14. MOTHER'S MAIDEN NAME <b>Mary Ann Beal</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Flossie Dodson-daughter-same 2d</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>450.0 Congestive heart failure</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (c) <b>Generalized arteriosclerosis</b> DUE TO _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ DUE TO _____						INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Feb. 1958</b> to <b>Feb. 2, 1961</b> , that (I) (we) last saw the deceased alive on <b>Jan. 30, 1961</b> , and that death occurred at <b>AM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>A. F. Thibadeau</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>A. F. THIBADEAU</b>				22d. ADDRESS <b>10111 Colesville Rd., Silver Spring Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/5/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Beth. Meth. Church Cem</b>		23d. LOCATION (City, town, or county) (State) <b>Browningsville, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>				ADDRESS <b>Bethesda, Maryland</b>		25a. REC'D BY REGISTRAR DATE <b>FEB 3 '61</b>	
				25b. REGISTRAR'S SIGNATURE <b>Charles S. Thayer</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be returned to the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1815



TO HOSPITAL OR DURING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Pages 3 and 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
2182									
02159									
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda, (Rural)</b> c. LENGTH OF STAY IN 1b <b>207 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>U. S. Naval Hospital</b>					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Florida</b> b. COUNTY <b>Orlando</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>5701 Yucatan Drive</b> d. STREET ADDRESS <b>5701 Yucatan Drive</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>Richmond Willey WATKINS</b>					4. DATE OF DEATH Month <b>February</b> Day <b>27</b> Year <b>1961</b>				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Caucasian</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10-15-03</b>		9. AGE (In years last birthday) <b>57</b> IF UNDER 1 YEAR Months <b>7</b> Days <b>27</b> Hours <b>19</b> Min. <b>61</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Officer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Navy</b>		11. BIRTHPLACE (County & State, or foreign country) <b>California</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William WATKINS</b>					14. MOTHER'S MAIDEN NAME <b>Nellie SHEPHERD</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> <b>1916 to 1946</b>					16. SOCIAL SECURITY NO. <b>(W) Mrs. Anne Watkins, same as #2 above</b>				
17. INFORMANT <b>(W) Mrs. Anne Watkins, same as #2 above</b>					Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic adenocarcinoma, primary unknown</b> <b>199.2</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that <b>1</b> (this hospital) attended the deceased from <b>August 4, 1960</b> to <b>Feb. 27, 1961</b> , that <b>1</b> (we) last saw the deceased alive on <b>Feb. 27, 1961</b> , and that death occurred at <b>12:02PM</b> , from the causes and on the date stated above.									
22a. SIGNATURE <b>Joseph E. Statcher</b> M.D.					22b. DATE SIGNED <b>2-27-61</b>				
22c. PHYSICIAN'S NAME (Type) <b>J. E. STITCHER, LT, MC, USN</b>					22d. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>3-2-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		23d. LOCATION (City, town or county) (State) <b>Arlington Virginia</b>		
24. FUNERAL DIRECTOR'S SIGNATURE <b>R. A. Humphrey</b> R. A. Humphrey Funeral Home, Bethesda, Md.					25a. REC'D BY REGISTRAR DATE <b>MAR 2 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>		

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**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2183

**CERTIFICATE OF DEATH**

02160

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>			c. LENGTH OF STAY IN lb <b>3 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban Hospital</b>				d. STREET ADDRESS <b>3614 Spring St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>Leonard</b> Middle <b>Way</b> Last <b>Way</b>				4. DATE OF DEATH Month <b>February</b> Day <b>6</b> Year <b>19 61</b>				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>August 4, 1877</b>		
9. AGE (In years lost birthday) <b>83</b> yrs.		IF UNDER 1 YEAR Months <b>4</b> Days <b>2</b> Hours <b>0</b> Min.		IF UNDER 24 HRS. Hours <b>0</b> Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>ICC examiner</b>		11. BIRTHPLACE (State or foreign country) <b>Iowa</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Jessie Way (Wife)</b>		Address <b>As above</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asystole of the heart</b> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) <b>Adams - Stokes syndrome</b> (c) <b>Arteriosclerotic Heart Disease</b>							INTERVAL BETWEEN ONSET AND DEATH <b>5 min</b> <b>4 months</b> <b>2 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from <b>October 1960</b> to <b>February 6, 1961</b> , that (I) (we) last saw the deceased alive on <b>Feb 5 1961</b> , and that death occurred at <b>12:01</b> M, from the causes and on the date stated above.								
22a. SIGNATURE <b>Thomas F. O'Connor</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>2/6/61</b>		
22c. PHYSICIAN'S NAME (Type) <b>THOMAS F. O'CONNOR</b>				22d. ADDRESS <b>48, Battery Lane, Bethesda, Md</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2-9-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Prince George Co., Md.</b>		
24. FUNERAL DIRECTOR'S SIGNATURE <b>ROBERT A. PUMPHREY</b>				ADDRESS <b>Bethesda, Md.</b>		25a. REC'D BY REGISTRAR <b>FEB 9 '61</b>		
				25b. REGISTRAR'S SIGNATURE <b>Charles E. Kline</b>				

TO HOSPITAL: A. The low requires that the death certificate be executed within 24 hours after the death. B. The funeral director, after this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF BIRTH

1918

1

TO HOSPITAL OR FUNERAL HOME: Retained by the hospital or attending physician. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
2184  
CERTIFICATE OF DEATH  
02161

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Washington Sanitarium 3rd Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) e. STATE <b>D.C.</b> f. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> g. STREET ADDRESS <b>1300 Jonquil St. N.W.</b> h. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Louise Elizabeth Wayson</b>		4. DATE OF DEATH <b>February 15 1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 20, 1903</b> 9. AGE (In years last birthday) <b>57</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Virginia</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>HARRY Tabb</b>		14. MOTHER'S MAIDEN NAME <b>Grace Rolland</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Hospital records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Failure</b> <b>420-1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Myocardial infarction</b> (c) <b>6 hrs.</b> DUE TO (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>6 hrs.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Feb 8, 1961</b> to <b>Feb 15, 1961</b> , that (I) (we) last saw the deceased alive on <b>Feb 15, 1961</b> , and that death occurred at <b>11:30 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Lyste Williamson</b> M.D.		22b. ADDRESS <b>8700 Colesville Rd - Silver Spring, Md</b>	
22c. PHYSICIAN'S NAME (Type) <b>Lyste Williamson</b>		22d. ADDRESS <b>8700 Colesville Rd - Silver Spring, Md</b>	
23a. BURIAL, CREMATION, REMOVAL or Special - <b>burial</b>		23b. DATE THEREOF <b>2/18/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Rock Creek Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Washington, D.C.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Thos H Hines</b>		25a. REC'D BY REGISTRAR <b>FEB 20 '61</b>	
ADDRESS <b>2901-14th St N.W.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles S. Kenna</b>	

2181

①

no

no

Rock Creek Cemetery, Washington, D.C.

1901



Page 4  
TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The attending physician or other person authorized by the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death, may be relieved of this duty by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health.

Montgomery Co. Deputy Medical Examiner notified and released to hospital,

VR A15 (4)  
15M 9/59

2185

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

02162

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN lb <b>12 hrs.</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> d. STREET ADDRESS <b>208 Wayne Place, S.E., Apt. 201</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Dorothea</b> Middle <b>Yates</b> Last <b>WEEKS</b>		4. DATE OF DEATH Month <b>February</b> Day <b>3</b> Year <b>19 61</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-18-26</b>	9. AGE (In years last birthday) <b>34</b> yrs.	10. IF UNDER 1 YEAR Months <b>3</b> Days <b>19</b> Hours <b>61</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Telephone Operator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>- - - - -</b>		11. BIRTHPLACE (State or foreign country) <b>Tennessee</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Raymond YATES</b>		14. MOTHER'S MAIDEN NAME <b>Edna</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>415-32-0316</b>		17. INFORMANT <b>(H) G. J. Weeks, same as #2 above</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage, intracerebral, spontaneous</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <b>331X</b> DUE TO (c) <b>12 hours</b>		INTERVAL BETWEEN ONSET AND DEATH <b>12 hours</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>4:30AM</b>	
20f. (City or town) <b>Feb. 2</b>		20g. (County) <b>Feb. 3</b>		20h. (State) <b>19 61</b>	
21. I certify that <del>(X)</del> (this hospital) attended the deceased from <b>Feb. 2</b> to <b>Feb. 3</b> , 19 <b>61</b> , that <del>(X)</del> (we) last saw the deceased alive on <b>Feb. 3</b> , 1961, and that death occurred at <b>M</b> , from the causes and on the date stated above.					
22a. SIGNATURE <b>F. H. GILLES, LT, MC, USNR</b>		22b. DATE SIGNED <b>2-4-61</b>		22c. PHYSICIAN'S NAME (Type) <b>F. H. GILLES, LT, MC, USNR</b>	
22d. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-Shipment</b>		23b. DATE THEREOF <b>2-4-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>WashDC</b>		23d. LOCATION (City, town, or county) <b>Knoxville</b>		23e. (State) <b>Tenn.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers</b>		25a. REC'D BY REGISTRAR <b>FEB 8 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Christina S. Kram</b>	
25c. ADDRESS <b>W.W. Chambers Funeral Home, 1400 Chapin St., NW,</b>		25d. DATE <b>FEB 8 '61</b>		25e. SIGNATURE <b>Christina S. Kram</b>	

CERTIFICATE OF DEATH

1818

Location of death

Washington, D.C.

Residence (Part I)

U. S. Naval Hospital

1000 Rhode Island Ave., N.E.

Age

Sex

Color

Rank

Service

Reg.

Serial

Signature of Physician

Signature of Witness

Signature of Registrar

U.S. Naval Hospital (H) 1000 Rhode Island Ave., N.E.

U.S. Naval Hospital, Washington, D.C.

OFFICE

U.S. Naval Hospital, Washington, D.C.

U.S. Naval Hospital, Washington, D.C.

1-1-1

U.S. Naval Hospital, Washington, D.C.

U.S. Naval Hospital, Washington, D.C.

U.S. Naval Hospital, Washington, D.C.

U.S. Naval Hospital, Washington, D.C.

U.S. Naval Hospital, Washington, D.C.

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with  
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)  
15M 9/59

Item 18 Film 282  
3-10-61 ams

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02163

2186

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>28 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Amherst</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Monroe</b> d. STREET ADDRESS <b>Route # 2</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>Sadie</b> Middle <b>Mae</b> Last <b>Wells</b>			4. DATE OF DEATH Month <b>February</b> Day <b>22</b> Year <b>19 61</b>		
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>May 27, 1902</b>		9. AGE (In years last birthday) <b>58</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Nurses Aide</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Nursing</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Delaware Goolsby</b>			
14. MOTHER'S MAIDEN NAME <b>Blanche Martin</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			
16. SOCIAL SECURITY NO. <b>Unascertainable</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Carcinoid Syndrome</b> DUE TO 152.7 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Primary site ileum</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>4 years</b>					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>January 25 1961 to February 22 1961</b>	
20f. (City or town) <b>Feb. 22 19 61</b>		20g. (County) <b>8:05 p.m.</b>		20h. (State) <b>that (I) (this hospital) attended the deceased from January 25 1961 to February 22 1961, that (I) (we) last saw the deceased alive on Feb. 22 19 61, and that death occurred at 8:05 p.m. from the causes and on the date stated above.</b>	
21. I certify that (I) (this hospital) attended the deceased from January 25 1961 to February 22 1961, that (I) (we) last saw the deceased alive on Feb. 22 19 61, and that death occurred at 8:05 p.m. from the causes and on the date stated above.		22a. SIGNATURE <b>John A. Oates, M.D.</b> M.D. 22b. DATE <b>2/23/61</b>			
22c. PHYSICIAN'S NAME (Type) <b>JOHN A. OATES, M.D.</b>		22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2-25-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Davis Cemetery</b>	
23d. LOCATION (City, town, or county) <b>Shipsman, Va.</b>		23e. (State) <b>Shipsman, Va.</b>		23f. (State) <b>Shipsman, Va.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>St. H. Demaingo</b>		ADDRESS <b>Alex. Va.</b>		25a. REC'D BY REGISTRAR <b>DATE 2 7 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>		25c. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>			

9815

2187

## CERTIFICATE OF DEATH

02164

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING KENSINGTON</b>		c. LENGTH OF STAY IN 1b <b>56 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>VIERS MILL ROAD</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JOSEPH WILLIAM</b> Middle <b>WILDMAN</b> Last <b>WILDMAN</b>		4. DATE OF DEATH Month <b>FEB.</b> Day <b>3</b> Year <b>1961</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/21/69</b>
9. AGE (In years last birthday) <b>91</b>		10. IF UNDER 1 YEAR Months <b>1</b> Days <b>10</b> Hours <b>0</b> Min. <b>0</b>	11. IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter &amp; builder (retired)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>VIRGINIA</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>BURR WILDMAN</b>		14. MOTHER'S MAIDEN NAME <b>ELIZABETH LOVELESS</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>579-10-1841</b>	
17. INFORMANT <b>Mr. Mason W. Wildman, Viers Mill Rd, Kensington, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ventricular fibrillation</b> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral Vascular accident (stroke)</b> DUE TO (c) <b>10 weeks</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 weeks</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes melitus</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct 1957</b> to <b>Feb 3 1961</b> , that I last saw the deceased alive on <b>Jan 31 1961</b> , and that death occurred at <b>1 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>John N. Andrews</b>		ADDRESS (Street, city or town, state) <b>9601 Coleridge Rd Silver Spring Md</b>	
PHYSICIAN'S NAME (Type) <b>John N. Andrews</b>		DATE SIGNED <b>Feb 3 1961</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>2/7/61</b>	22c. NAME OF CEMETERY OR CREMATORY <b>FT. LINCOLN CEMETERY</b>	22d. LOCATION (City, town, or county) (State) <b>PRINCE GEO. COUNTY, MARYLAND</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond A. Jaska</b>		ADDRESS <b>SILVER SPRING, MD.</b>	
24a. REC'D BY REGISTRAR <b>FEB 9 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Charles E. Finner</b>	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

1915

NAME OF DECEASED

DATE OF DEATH

PLACE OF BIRTH

AGE

SEX

OCCUPATION

CAUSE

DIAGNOSIS

DATE OF EXAMINATION

SIGNATURE OF PHYSICIAN

DATE OF EXAMINATION

SIGNATURE

PLACE OF BIRTH

DATE OF DEATH

CAUSE OF DEATH

DATE OF EXAMINATION

SIGNATURE OF PHYSICIAN

DATE OF EXAMINATION

SIGNATURE OF PHYSICIAN

DATE OF EXAMINATION

SIGNATURE OF PHYSICIAN



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be revised by the attending physician or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

2188

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

02165

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>West Virginia</b> b. COUNTY <b>Beckley</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>67 Days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		d. STREET ADDRESS <b>Star Route, Box 29</b>	
3. NAME OF DECEASED (Type or print) First <b>Faye</b> Middle <b>Elizabeth</b> Last <b>Wiley</b>		4. DATE OF DEATH Month <b>February</b> Day <b>28</b> Year <b>19 61</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 12, 1915</b>
9. AGE (In years last birthday) <b>46</b> yrs.		IF UNDER 1 YEAR Months <b>4</b> Days <b>28</b> Hours <b>11</b> Min. <b>20</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Store Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Store</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles Edwards</b>		14. MOTHER'S MAIDEN NAME <b>Martha Ann Fine</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>Unascertainable</b>	
17. INFORMANT <b>The Medical Records</b>		<b>The Clinical Center, Bethesda 14., Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myelogenous Leukemia</b> 204.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>204.3</b> DUE TO (c) <b>204.3</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>December 23, 1960</b> , to <b>February 28, 1961</b> , that (I) (we) last saw the deceased alive on <b>February 28, 1961</b> , and that death occurred at <b>11:20 p.m.</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Edward E. Morse</b>		22b. DATE <b>3/1/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>EDWARD E. MORSE, M.D.</b>		22d. ADDRESS <b>The Clinical Center National Institutes of Health Bethesda 14, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>3/3/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>MT TABOR CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>Beckley W. Va.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>W W Chambers</b>		25a. REC'D BY REGISTRAR <b>DATE MAR 3 '61</b>	
ADDRESS <b>1400 CHAPIN ST. N. W. WASHINGTON D.C.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraw</b>	

2188

STATE OF CALIFORNIA

1918

County of \_\_\_\_\_

City of \_\_\_\_\_

State of California, \_\_\_\_\_

County of \_\_\_\_\_

City of \_\_\_\_\_

State of California, \_\_\_\_\_

County of \_\_\_\_\_

City of \_\_\_\_\_

State of California, \_\_\_\_\_

TO HOSPITAL OR FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MONTGOMERY COUNTY											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
2189											
CERTIFICATE OF DEATH											
02166											
1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TAKOMA PARK</b> c. LENGTH OF STAY IN 1b <b>45 years</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>WASHINGTON SANITARIUM AND Hospital</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TAKOMA PARK</b> d. STREET ADDRESS <b>7120 PINEY BRANCH ROAD</b>					
3. NAME OF DECEASED (Type or print) <b>DOROTHY</b> First <b>Lillian</b> Middle <b>Wilkinson</b> Last						4. DATE OF DEATH Month <b>Feb</b> Day <b>2</b> Year <b>1961</b>					
5. SEX <b>Female</b> 6. COLOR OR RACE <b>White</b>						7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					
8. DATE OF BIRTH <b>11-1-88</b>						9. AGE (In years last birthday) <b>72</b> yrs.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>						10b. KIND OF BUSINESS OR INDUSTRY					
11. BIRTHPLACE (County & State, or foreign country) <b>District of Columbia</b>						12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>					
13. FATHER'S NAME <b>FRANK Hovvis</b>						14. MOTHER'S MAIDEN NAME <b>Elizabeth Neshe</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>						16. SOCIAL SECURITY NO. <b>WASHINGTON SANITARIUM and Hospital Records</b>					
17. INFORMANT <b>WASHINGTON SANITARIUM and Hospital Records</b>						18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of the uterus</b> 174X DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) DUE TO (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						INTERVAL BETWEEN ONSET AND DEATH <b>2 1/2 years</b>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)						20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <b>Nov 10</b> , 19 <b>58</b> , to <b>Feb 2</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>Feb 1</b> , 19 <b>61</b> , and that death occurred at <b>3:40</b> AM, from the causes and on the date stated above.											
22a. SIGNATURE <b>Abraham W. Danish</b>						22b. DATE SIGNED <b>2-2-61</b>					
22c. PHYSICIAN'S NAME (Type) <b>ABRAHAM W. DANISH</b>						22d. ADDRESS <b>927 PERSHING DR.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>						23b. DATE THEREOF <b>Feb 5, 1961</b>					
23c. NAME OF CEMETERY OR CREMATORY <b>George Washington Cemetery</b>						23d. LOCATION (City, town or county) (State) <b>Prince George Co, Md.</b>					
24. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur Walter</b>						25. REC'D BY REGISTRAR <b>FEB 6 '61</b>					
25a. ADDRESS <b>254 Carroll St NW DC</b>						25b. REGISTRAR'S SIGNATURE <b>Arthur S. Harris</b>					

51880

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TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

VR A15 (4)  
ISM 9/59

1  
2190  
02167  
MONTGOMERY  
Kensington  
Bensington Sanders  
Lucille First Dutton Middle Williams Last  
female white  
Arterial Thrombosis, all left leg & thigh and rt leg  
Arteriosclerosis, severe, general  
Essential Hypertension, severe  
Old left hemiplegia, severe  
Stewart Clapp  
Stewart Clapp  
Cedar Hill Cemetery  
Prince George County, Md.  
Bethesda, Md.  
FEB 17 '61  
Arthur S. Kram

MARYLAND  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Bensington Sanders</u>		d. STREET ADDRESS <u>3221 Oliver St., N. W.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Lucille</u> First <u>Dutton</u> Middle <u>Williams</u> Last		4. DATE OF DEATH Month <u>2</u> Day <u>14</u> Year <u>1961</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 23, 1885</u>
9. AGE (In years last birthday) <u>75</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Cleveland Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>	
13. FATHER'S NAME <u>Mr. Leavelle Dutton</u>		14. MOTHER'S MAIDEN NAME <u>Mary Elizabeth Billmeyer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Daughter</u>		Address <u>3221 Oliver St.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterial Thrombosis, all left leg &amp; thigh and rt leg</u> DUE TO <u>444X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis, severe, general</u> DUE TO <u>10 yrs +</u> (c) <u>Essential Hypertension, severe</u> DUE TO <u>10 yrs +</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Old left hemiplegia, severe</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 <u>61</u> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>			
20d. INJURY OCCURRED			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>1946</u> to <u>Feb 14, 1961</u> , that (I) (we) last saw the deceased alive on <u>Feb 14, 1961</u> , and that death occurred at <u>4:45 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Stewart Clapp</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>2.15.61</u>			
22c. PHYSICIAN'S NAME (Type) <u>Stewart Clapp</u> 22d. ADDRESS <u>4740 Chevy Chase Dr Chevy Chase Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (specify) <u>Burial</u>		23b. DATE THEREOF <u>2-16-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Prince George County, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>ROBERT A. PUMPHREY</u>		ADDRESS <u>Bethesda, Md.</u>	
25a. REC'D BY REGISTRAR <u>FEB 17 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kram</u>	

CERTIFICATE OF DEATH

3100

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VR AIS (4)  
15M 9/59

CERTIFICATE OF DEATH

1018

Virginia

Virginia

(Date)

U. S. Social Security Administration

File

Consent

Signature

Michael A. Smith

Michael A. Smith

Michael A. Smith

1

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U. S. Social Security Administration

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U. S. Social Security Administration

## CERTIFICATE OF DEATH

02169

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>56 Chevy Chase</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban Hospital</b>				d. STREET ADDRESS <b>4511 Willard Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>CLAUDE</b> Middle <b>H.</b> Last <b>WOODWARD</b>				4. DATE OF DEATH Month <b>Feb.</b> Day <b>8,</b> Year <b>1961</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 12, 1877</b>		9. AGE (In years last birthday) <b>83</b> yrs.	IF UNDER 1 YEAR Months <b>2</b> Days <b>26</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Wallace Woodward</b>				14. MOTHER'S MAIDEN NAME <b>Ella Simmons</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>579-12-2357</b>		17. INFORMANT <b>Daughter</b>		Address <b>Mrs. Mildred Shoemaker - Same as Item 2.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> <b>Uremia &amp; congestive heart failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Myocardial Infarction and</b> DUE TO (c) <b>arteriosclerotic heart and kidneys</b>							INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>16 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 1939</b> to <b>Feb 8, 1961</b> , that (I) (we) last saw the deceased alive on <b>Feb 7, 1961</b> , and that death occurred at <b>2:24</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>Gilbert B. Rude</b>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> M.D.		22b. DATE SIGNED <b>Feb 8, 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>Gilbert B Rude.</b>				22d. ADDRESS <b>3900 Military rd N.W.DC.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2-11-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rock Creek Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Washington, D. C.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>ROBERT A. PUMPHREY</b>				ADDRESS <b>Bethesda, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>FEB 14 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>							

8193

RECORD OF DEATH

Gray, Mary

1871

Washington

1870-1871

Gray, Mary  
1870-1871

C

1871

1871

1871

1871

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2193

## CERTIFICATE OF DEATH

02170

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>14 Days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Fairfax</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Falls Church</b> d. STREET ADDRESS <b>5912 Kirby Court</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Georgia</b> Middle <b>Inez</b> Last <b>Young</b>		4. DATE OF DEATH Month <b>February</b> Day <b>7,</b> Year <b>19 61</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 27, 1887</b>
9. AGE (In years lost birthday) <b>73</b> yrs.		10. IF UNDER 1 YEAR Months <b>73</b>	11. IF UNDER 24 HRS. Days <b>73</b> Hours <b>73</b> Min. <b>73</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Georgia</b>	
11. BIRTHPLACE (State or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Lowe</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Stead</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Not Available</b>	
17. INFORMANT <b>The Medical Record,</b>		18. ADDRESS <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pseudomonas aeruginosa septicemia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Multiple myeloma</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>3 years</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <b>Dr.</b> (this hospital) attended the deceased from <b>January 24, 19 61</b> , to <b>February 7, 19 61</b> , that <b>Dr.</b> (we) last saw the deceased alive on <b>Feb. 7, 19 61</b> , and that death occurred at <b>12:35 PM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Wendell F. Rosse</b>		22b. DATE SIGNED <b>2/7/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Wendell F. Rosse, M.D.</b>		22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>2/8/1961</b>	23b. DATE THEREOF <b>2/8/1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Bairdstown, Georgia</b>	23d. LOCATION (City, town, or county) (State)
24. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H.Hines Co., 2901 14th St. N.W.,</b>		25a. REC'D BY REGISTRAR DATE <b>FEB 9 1961</b>	
25b. REGISTRAR'S SIGNATURE		25c. REGISTRAR'S SIGNATURE	

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